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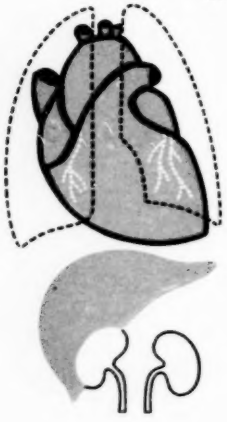

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The Journal
of the
South Carolina Medical Association

VOLUME LI | September, 1955 | NUMBER 9

INDUSTRIAL HEALTH IS YOUR BUSINESS!

EDWARD M. GUNN, M. D.
Hartsville, S. C.

You believe it is more blessed to receive than to give. You enjoy levelling criticism but you rebel when criticized. You complain of what industrial nurses and management do, but you do not put the right hand of friendship forward nor try to understand nor constructively advise on employee health and welfare matters. You like to treat but you do not like to prevent disorders of health. You think of health in physical terms mostly, in emotional terms occasionally, in spiritual and social terms rarely.

These are not my original thoughts, but they are typical expressions of those who are intimately associated with the health and welfare of workers.

It is my intent to outline some of the aspects of this situation so that you will see for yourself that employee health is your business.

We will start our "for instances" with the objectives of the American Association of Industrial Nurses (AAIN) which are:

1. To develop further the field of industrial nursing.
2. To develop sound standards of education, practice, and policies in industrial nursing.
3. To cooperate with industrial physicians, management and other allied groups in the conservation of the health of the worker.

The AAIN with its Management Advisory Council informs all management that it (management) should organize its health service with full recognition of the legal, ethical, and professional principles of medical nursing services in industry.

It announces openly that management should arrange for a physician to have full responsibility for the medical program in its plant, such a physician to be on a full-time, part-time, per diem, or consultant basis. Provision should be made for the industrial nurse to act under the direction of such physician and be responsible for her professional activities which have to do with the practice of medicine.

The AAIN honestly demands and expects direction from the medical profession. It has a sixteen member Medical Advisory Council which has the following functions: (partial)

1. To act in an advisory capacity to the AAIN in matters concerning physicians, industrial nurses, and industrial nursing.
2. To formulate jointly statements on principles and policies related to Industrial Medicine and Industrial Nursing.
3. To counsel the AAIN on matters related to medicine and on matters needing medical guidance.

The industrial nurse should not be called upon to give service or to make decisions upon professional matters involving the practice of medicine which do not properly fall within the field in which she is licensed to practice.

All this is evidence, which can be confirmed by one example after another, of how the nurses know what they need, but it may be said we sit idly by and criticize rather than accept our responsibilities to them, management, and their workers (our patients).

AAIN authorities consider industrial health nursing as one of several nursing specialities, it

Read at the First Annual Seminar on Industrial Health, at the Medical College of South Carolina, March 17, 1955.

is dependent upon a sound nursing educational experience, and it includes some proficiency in the following additional understandings, appreciations, and skills before she can participate efficiently as an industrial nurse:

1. Industry; including industrial organizations and operations, and labor management relations.
2. Workmen's Compensation legislation.
3. Occupational health hazards and methods of control.
4. Selective placement procedure.
5. Modern health and accident insurance programs.
6. Communication skills.
7. Doing health teaching and health counseling.
8. Giving anticipatory guidance.
9. Community resources and proficiency in helping people to use them.
10. Recording and record keeping.

How can these most important factors be evaluated properly by management if physicians do not accept their responsibilities as the qualified advisors on matters pertaining to health? If we do accept our responsibilities, how can we help but gain personally in prestige, knowledge, and worldly goods?

The AMA has a long established interest in industrial health. The latest approved "Guiding Principles of Occupational Medicine" were published on pages 364-365, Vol. 155 ,No. 4, JAMA, May 22nd, 1954. Included is a statement of definitions and purposes: "Occupational medicine concerns itself with all aspects of health in relation to occupation. Industrial medicine is a component of occupational medicine provided to employed groups by an employer or other third party with a valid interest. The broad purpose of industrial medicine is the promotion of the healthful well-being of employed persons through services provided at the place of employment or at another convenient facility or location. This purpose is served by: (1) prevention of disease and injury through medical supervision of workers, the work place, materials, and processes; (2) constructive measures such as medical examinations, counseling, and health education; and (3) medical and surgical care to restore health and productive capacity as promptly as possible after occupational illness and injury".

It would seem each of us is qualified and in a position to do a great deal more to assist in furthering such a health conservation program. Each thing we do brings us desirable rewards of various types. I urge you to become acquainted with the remainder and more important portions of this reference, for it pertains to everyone practicing medicine.

The Industrial Medical Society of South Carolina and the Industrial Medical Association have essentially the same object, which is "to foster the study of the problems peculiar to the practice of industrial medicine and surgery, and to unite into one organization licensed members of the medical profession whose interest lies in that field. It shall encourage the development and application of methods adapted to the conservation and improvement of health among workers, and promote a more general understanding of the purposes and results of the constructive medical care of these workers".

A worthy objective and one to which I feel any good practitioner of medicine and surgery would readily subscribe.

A progress report of the Investigation of the Costs of Employee Sickness and Health Services by Research Teams at the Universities of Pittsburgh and Michigan, as of January 19, 1955, indicated the magnitude of the problem which surrounds us, confronts industry, and establishes the health of the employed as a socio-economic must. It is evident that we as physicians can not retire to an "ostrich-head in the sand" position, for we are automatically included. It is our duty and our gain to get in and make our voices heard in a constructive manner.

In 1930, there were approximately 3,720 nurses in industry; in 1954, there were 14,000.

In 1930, there were 29,140,000 civilian non-agricultural employees in industry; in 1954, 48,280,000.

In 1930, there were 1.3 nurses per 10,000 employees; in 1954, 2.9 per 10,000 employees.

Small plant costs to management of employees sickness and injury show:

	Median Annual Cost per Employee in dollars	
1. Premiums for workmen's compensation	22.60	
2. Compensated sick leave	12.50	
3. Employee sickness and accident care	16.65	
4. Death benefits to worker's families	5.00	
5. Indirect costs	62.19	
6. Emergency medical service	0.22	
7. Clerical and managerial time	0.30	Range
Partial Total	$119.46	$8.69 to $880.53

Costs of Major Fringe Benefits Attributable to Employee Sickness and Injury for each type of industry shows the following average amounts paid by industry per employee per year:

1. For Workmen's Compensation premiums	$29.52
2. For Paid Sick Leave	18.68
3. For Insurance Other than Work. Comp.	65.58
4. For all coverage	113.79

Calculated for the 48,280,000 employed, it means industry itself is paying approximately 5-1/2 billions annually for employee health benefits. If you and I knew we were paying that figure, I believe we might expect a greater interest on the part of physicians. As physicians, I believe it is our business and our duty to show a greater personal interest, since it is important for those who pay the bills to be convinced we are serving the workers in everyway possible. Just because we say we are giving the best is not sufficient evidence as far as others are concerned..

In South Carolina some industries experienced a rise in the amount of health benefts paid of 12 percent in 1953 over 1952 and 26 percent in 1954 over 1953. We are being called upon at least indirectly to show the way by which costs may be held within reasonable limits. Certainly, if costs become out of the question, insurance coverage by private enterprise will cease to exist, and then we as physicians will be placed in an unpleasant situation.

It may also be interesting to you to learn that in one typical situation here in South Carolina, the following factors prevail. One employee absent sick for one to six days loses $14.49 and costs his employer $7.53 per day. If he is out seven days or longer, the employee loses $8.99 per day and costs his employer $12.39 per day. If he is in the hospital and absent seven or more days, he loses $11.57 daily and his employer $21.03. If he is in the hospital, undergoes surgery, and is absent seven or more days he loses $12.43 daily and his employer $24.35.

It seems obvious that both the worker and his employer has an interest in this matter of health for which we are responsible. Possibly, we as physicians would benefit by getting into case finding in industry which would in turn permit us to treat various conditions while the worker and his employer are earning money rather than waiting to treat when both are losing money.

Moderately active case finding in one South Carolina plant has benefited the physicians in its community. The annual average number of employees seeing their physicians 3 and 4 years ago was 297 per year and last year it was 498. That means an increase in business or shall we say practice for the doctors of 67 percent. The total number of employees from which the patients came during the noted periods remained essentially constant.

You and I may think that all the talk and interest in occupational medicine and health has little to do with us. May I be so bold as to presume to tell you, I think we as physicians are not tending to our business. By default, by a spirit of individual isolationism, and by the nature of the socio-economic changes in progress we are letting others less qualified direct the course of events as they pertain to health and possibly welfare, too.

Do you want to have the future of medicine directed by, medical opinions rendered by, and evaluations of medical care and service made by personnel officers, safety directors, labor groups, nurses, governmental persons, and plant managers? That is just what is going on now and will be standard practice if the physicians and surgeons in every community do not go into the industrial plants, attend meetings at which relevent matters are discussed, and give constructive (not narrow protective)

advice. Every major group, be it political, labor, management, or medical, is working toward the provision of the best in medicine and health for the common man. It is your business and my business to make certain every possible measure is taken to prevent illness, injury, and death, just as much as it is your business and mine to return all who are sick and injured to the best possible state of health.

At the recent Fifteenth Annual Congress on Industrial Health which convened in Washington, D. C. many phases of the overall subject of occupational health were discussed.

1. The council on Industrial Health of the American Medical Association held a joint session with the Board of Directors of the Industrial Medical Association on a Sunday. Subjects covered were: corporations and medical practice and corporate medical practice, legal aspects of the various approval programs, a preview of legislation, general practice and industrial medicine, a revision of standard procedures for nurses working in industry, educational emphasis being placed on industrial medicine by the AAGP, and a proposal by the representative body of neuropsychiatrists to enter into a joint consideration of the emotional problems of workers.

2. Representatives of thirty-nine State Medical Society Committees on Industrial Health held a one-day session. The Office of Vocational Rehabilitation, the Occupational Health Program of the Public Health Service, and the facilities of the National Institutes of Health were described and shown to all present. The hopes and aspirations of the Public Health Service were made manifest at that Monday meeting.

3. Tuesday and Wednesday witnessed all day sessions for each of three groups. The first was devoted to Occupational Health—Major Factor in Community Health. The second covered the Impact of the Atomic Energy Industry on Community Health. The third was devoted to the Challenge of Occupational Disability.

I will mention but a few participants to further emphasize the magnitude of that which is before us. Representatives of the American College of Surgeons, Liberty Mutual Insurance Company, Atomic Energy Commission, A. F. of L., Institute of Living, American Heart Association, Public Health Service, United Mine Workers of America, American Academy of Compensation Medicine, Department of Labor, International Association of Machinists, Dr. Walter B. Martin, President and Dr. Elmer Hess, President-Elect, AMA, NACCA Law Journal, Chamber of Commerce of the U. S. A., University of Pittsburgh, University of Cincinnati College of Medicine, Birmingham Paper Company, The Texas Company, UAW and CIO, American Bar Association, American Association of Industrial Nurses and many many others.

In summary, I challenge you to deny that industrial health is your business. The magnitude of the costs involved in caring for the health needs of the industrially employed has been indicated. The majority of the influences in the nation recognize the need for good occupational health programs. The industrial nurses recognize the need for proper medical supervision. Some elements of management recognize the need for qualified medical supervision of their occupational health programs. All industry needs sound constructive medical thinking for advice and guidance. The governmental interests see all aspects and their opportunities.

Each one of you have a responsibility for taking another look at yourself. Each of you should look within yourself, too. Is the present motivation of some practitioners selfish, narrow, or short-sighted? Is your motivation lacking in the force that reflects the benefits to be derived from a willingness to understand, cooperate, and look ahead with the people who support you?

It is past time when you can be certain of the future unless you are going to participate in your local community industrial situations, in statewide programs, and in national affairs. Things just don't happen—they are the result of someone's efforts. If you want or expect to enjoy all the luxuries of our prosperous life as the social and economic changes develop, you must be ready to contribute your thinking and show that the benefits of the future are your business.

WHAT INDUSTRY EXPECTS FROM THE MEDICAL PROFESSION*

R. M. Frew
Columbia, S. C.

My assignment is to discuss with you "What Industry Expects from the Medical Profession." If any of you feel that we are rather presumptious in telling you what we "Expect" let us interpret it as meaning "What Industry would like from the Medical Profession."

These remarks will not be based on my experiences alone. I sought and secured the experience of others in industry, in the insurance business, and the medical profession. I was impressed with the remarkable unanimity of opinion.

Believe it or not we are pretty good customers of yours. There are several reasons for believing this:

1. The tremendous increase in companies requiring pre-employment physical examinations.

2. The growing insistence that any employee returning from sick leave have the approval of a reputable doctor.

3. The requirement that a person injured in the course of his employment receive immediate medical attention.

4. The furthering of the idea that periodic physical examinations are beneficial to the welfare of employees.

5. The sponsoring of health clinics for children of employees.

All these add up to a sizable volume of business for you gentlemen of the medical profession.

Industry, by its nature representing a concentration of people, offers you what might be called a package deal.

South Carolina Industry employs approximately 192,760 (1953) wage earners, 133,555 or 69% of these are in the textile industry, and the State has not yet reached its industrial potential. The textile industry is the pioneer, in South Carolina at least, in placing a high value on the good health of its employees. New industries coming into the state can do no less. This alone indicates an expanding need for competent medical services.

Come to think of it, industry by keeping its employees health conscious, is doing a pretty good public relations job for the medical profession. By providing its employees with various kinds of insurance—health, accident, hospitalization, and surgical—industry offers its employees the means with which to pay for your services. This is for the good of all concerned.

In South Carolina (1953) 1,078,000 persons were covered by Hospital Expense Insurance, 903,000 by Surgical Expense, and 207,000 by Medical Expense. I feel safe in saying that the vast majority of these people are insured under plans provided, and in a large measure paid for, by industry.

These things give industry a vital interest and concern in the attitude of the medical profession toward our problems.

The growth of industry has been paralleled by the expansion of interest in industrial medicine. Practically all industries have access to professional services, varying from doctors on a call in basis to a full time medical staff.

What industry expects from the Medical Department is threefold:

1. Care for the physical well-being of its employees.

2. Protection from *unjust* claims for workmen's compensation.

3. To serve as a medium for maintaining good relations between the employee and the employer.

The first two of these are purely professional. The third requires that element which measures your success in private practice—a personal interest in your patient—plus a knowledge and appreciation of the problems of the Company it represents.

*Presented at the Seminar on Industrial Health, Medical College of South Carolina, March 17, 1955.

Industry has a right to, and does, expect its Medical Staff to acquaint itself with the problems of industry. It is our hope that they will also, in their associations with their colleagues, increase their consideration of our problems. Thus far, I do not believe we can boast of much success in that field.

Since I propose to approach this subject from both the standpoint of Workmen's Compensation, and of Health Insurance, let us review first some of our problems connected with Workmen's Compensation.

Industry recognizes and accepts its responsibility to compensate its employees adequately for injuries sustained in the course of their employment. No reputable industry expects a member of your profession, either in private practice or on its Medical Staff to give other than a professional appraisal of the extent of an injury. On that appraisal, and that alone, it will determine whether it will concede or resist the payment of compensation.

I am sure that most of you are familiar with some of the problems South Carolina has had with regard to Workmen's Compensation. I am happy to say that the past few years have witnessed a tremendous improvement in the administration of the law.

If I were to limit myself to just one hope it would be that you gentlemen, when testifying in Workmen's Compensation cases, would give positive answers to questions asked at such a hearing. Vague and indeterminate answers, capable of multiple interpretations, do not lead to a decision based on fact. I am fully aware that diagnosis is not an exact science. Yet diagnosis can lead to a positive opinion. If all awards for compensation were based on positive medical opinion derived from adequate diagnosis there would be little about which industry could complain.

While on the subject of compensation cases let me repeat a statement I have previously made—"Industry recognizes and accepts its responsibility to compensate its employees adequately for injuries sustained in the course of their employment."

Now let me suggest some things that would simplify our problems:

1. On alleged injuries the doctor should have some contact with the employer (through its Medical Department) before a comitment is made.

2. Except in emergency cases, the employee should not be placed in a hospital for reasons based only on the employee's story.

3. An effort on the part of those doctors who deal with compensation cases to become reasonably familiar with working conditions in industrial plants. This could be helpful in promoting harmony between the worker and his employer by showing a personal interest in both. It also might save us in industry from receiving a doctor's statement such as this—"Mrs._____ *might* be able to do *light* work *part time*." It is a characteristic of private enterprise that it must conduct its business efficiently. We could not long survive with jobs such as that doctor wanted us to provide.

4. In visits to your patients advice on preventing accidents would be helpful to both the patient and his employer.

5. Recognition of the fact that an injured employee receiving compensation is losing money. The sooner he is able to return to work the better off he is. Only the malingerers try to stay out from work after maximum recovery is attained.

Industry is doing a tremendously able job in accident prevention. We can proudly say, "It is safer to be at work than at home". With the wholehearted cooperation of the medical profession we can do even more to make workers safety conscious.

Compensation cases are not our only problem, however. The health insurance provided by most of us is, each year, becoming a matter of greater concern, I think to such an extent that, sooner or later, drastic action may have to be taken.

Industry is faced with the immediate problem of retaining present benefits, insurance companies with the long range problem of providing adequate coverage at a reasonable cost, and the medical profession with helping us to solve these problems. It will take the combined efforts of all three groups to preserve something that is not only of economic benefit, but a contribution to the physical well being of the people of our state and country.

Insurance provided by Industry is one of those "fringe benefits" you read so much about these days. Call it what you wish it is still a part of our cost of doing business. Just like any other cost that is not producing the required result it is subject to scrutiny and correction.

There is no thought of eliminating insurance from our costs. But to stay in line it can easily become necessary to reduce the coverage or to require a waiting period before coverage begins. No one in industry likes that prospect but when the cost of an article becomes prohibitive, industry, like an individual, has no recourse but to restrict the use of it. That is simple economics.

With the cooperation of the medical profession we can prevent that from becoming necessary. We want you to give our employees the best possible care. We want you to know more about the type work these employees do so that you can better judge when they have recovered sufficiently to return to work, and we want you to realize, as we do, that insurance is not designed to relieve the patient of all responsibility but to help relieve the financial burden of his illnesses.

To better illustrate my point let me read what a member of your profession has said about some abuses that might force a retrenchment in health insurance plans. He was referring to certain physicians who "ride" health insurance policies. I quote:

1. "Admittance to hospitals for purely diagnostic purposes only. These admittances can easily have had their investigative studies done either at the doctors' offices or as out-patients.

2. "Patients receiving X-Ray therapy or physiotherapy in hospitals when they can be treated on an out-patient basis and not be hospitalized.

3. "Patients who receive prolonged preoperative medication and treatment as a matter of convenience for the doctor and to conform to his operative schedule of only certain days at hospitals or certain hours.

4. "Orthopedic patients with prolonged hospital stay even though they are ambulatory.

5. "Overmedication.

6. "The ordering of unnecessary laboratory procedures."

These are excerpts from the Inaugural Presidential address of Dr. John R. Thompson, Jr., read before the Tennessee State Medical Association at Nashville on April 19, 1954.

Dr. Thompson did not place the entire blame on doctors. He placed some responsibility for those situations on (a) the hospitals, (b) the patients, (c) the public, and (d) the insurance companies.

I will add one more—Industry itself. We have been reluctant to proclaim our position in the matter. In a rather mild manner that is what I am doing now.

We are living in a time when the whole atmosphere seems filled with the idea of something for nothing. It is dangerous for those of us who consider ourselves responsible citizens to further that idea. It goes far beyond any immediate convenience it might be for us to overlook it. This something for nothing attitude leads to but one result—let the government handle it. Neither Socialized Industry nor Socialized Medicine has any appeal to me.

On May 31, 1953, at a conference of Presidents and other Officers of State Medical Associations, Mr. Carrol M. Shanks, President of The Prudential Life Insurance Company had this to say: I quote:

"The physician must and should be adequately compensated for his work, and our plans must be kept financially sound—not only for ourselves but for the participants in the plan. But we must still see the job is done at a cost which the patient may reasonably be expected to pay. Should we fail to meet the reasonable expectation of the public in this regard, the solution will not be abandonment of public demand for adequate coverage but a turn to some governmental operation."

Industry is your strongest ally in hoping this last will not come true. We do have similar problems and problems are resolved only when they are understood and there is a cooperative effort to resolve them.

There is another field where the medical profession can be of great help, not only to industry as such, but even more to the individual employee. This has to do with the treatment of non-covered illnesses. By that I mean those where neither compensation nor insurance is

involved.

We go along wholeheartedly with the idea that a person who is ill should not be at work. We readily excuse those who are absent because of illness.

Yet the person who is absent and alleges illness is of growing concern to us. We know he is a problem to you also. We do not propose to suggest to you how to run your business. But if it were possible, along with your medication, to talk to the chronic absentee on his responsibility to his job and to his family your influence could help strengthen his character and make of him a better citizen.

Believe it or not, but industry is vitally concerned with the preservation of those professions and institutions that have helped make this a great country. All of us are aware of those subversive elements that would like to see these things destroyed and replaced with something else. It behooves us individually, and collectively, to use our influence to preserve and promote those things in which we believe.

I am grateful to you for the privilege of appearing before you today. What I have had to say is not to be interpreted as an indictment of anyone. It has been merely a factual recitation of some of industry's problems as they concern you.

Summarized in a brief paragraph, "What Industry Expects from the Medical Profession" is a cooperative effort to eliminate some of the problems we both have and to prevent greater ones from arising.

RELATIONSHIPS OF THE COMMUNITY AND HOSPITALS TO THE FUTURE PRACTICE OF MEDICINE

ANTHONY J. J. ROURKE, M. D.
Hospital Consultant
New Rochelle, N. Y.

Mr. Chairman, Honored Guests, Brother Physicians and guests:

It is a great pleasure to share with you this afternoon the joy of passing another milestone in your outstanding activities. The commemoration day of your new modern hospital is that milestone. You may well be proud of the years of hard work which went into the planning, and I am confident you and the citizens of Greenville and South Carolina will feel well rewarded for your efforts.

I wish it were possible for me to tell you that after these years of hard work you may rest now and coast for a few years while you catch your breath. But I am reminded of a statement credited to my friend Dr. Ted Hill of Maine, who said, after having spent a life time in that Republican state, that the only way you can coast is down hill.

You invited me here today to give you the benefit of my crystal ball gazing into the future Practice of Medicine as it relates to Communities and Hospitals. So without further ado, let me tell you what I see.

American medicine has come a long way in the last century. Organized medicine has contributed immeasurably to this success. The Councils of Medical Education and Hospitals and of Pharmacy of the A.M.A., to mention just two, have greatly assisted in raising and maintaining high standards of medical education and in controlling quackery among the drug peddlers.

As our profession has improved and grown, as miracle drugs and miracle surgery have taken the spotlight and as the potentialities of our profession have been accepted, more and more people have tried to pull a Durante—namely, everybody wants to get into the act.

First it was the desire of government to take over. Now that is changed, and let us hope that we were not pushing so hard that with the removal of that pressure we will fall over on our noses. For nearly twenty years doctors

Address given at Greenville General Hospital, November 5, 1954.

have been waging a defensive war not confined to disease alone, but also against those who would take over. Nearly 100,000 physicians practicing today who were graduated since '32 have known only a practice of armed conflict.

But we must remember that all our citizens reaching 21 since 1932 up to 1952 knew only one-party type of government. It was prophesied the two party system had ended. And then the people spoke and more people spoke than ever before, and they spoke with overwhelming emphasis. And they spoke because they were not satisfied.

In my mind the greatest catastrophe which could happen to American medicine after 20 years of fighting a battle which we have won, would be that we have become mice who have learned only one track thru the maze and are not interested in nor capable of exploring other areas.

The battle is over and I hope we are not left as "old soldiers" weary of battle, fixed in ideas, and therefore bankrupt. If we are, the people will again speak and we too may be sent to Missouri.

There is a big job ahead, there are other disturbing signs in the wind, so let's look at them. Organized labor is expressing an interest to get into the act. Their recent proposals in San Francisco and the minority report by Walter Reuther of the C.I.O. and Al Hayes of the A.F.L. in the President's Commission Report should convince you that they mean business. Other hearsay evidence seems to be accumulating.

There seems to be an unwillingness in some areas to settle Doctor-Hospital differences. We are hearing, all too often, dissatisfaction on the part of physicians with prepayment plans. One hears more frequently than is healthy some public dissatisfaction with financial arrangements between doctors and patients. We are continually being charged at the bar of public opinion of not solving or being interested in catastrophic or long-term illness. There are rumors that doctors tailor the number of tests and length of hospital stay to the unexpended portion of prepayment policies. You have all heard the stories that hospital staff appointments seem to be harder to get in some areas and thus doctors are discouraged from locating in the neighborhood. It has been said patients are frequently hospitalized for the doctors' convenience, not the patients' need. We have seen some discontent within the profession resulting in new organizations seeking recognition — most notable example being the Academy of General Practice. Undesirable physician-druggist combines were recently reported in New York papers, while earlier the same papers reporting the American College of Surgeons meeting, carried stories on fee splitting. We continually hear of doctors exploiting hospitals, hospitals exploiting doctors and established doctors exploiting younger doctors. Last week I heard a nasty rumor of an anesthetic "combine" where the resident gave the gas, the anesthetist sent the bill and the hospital charged for materials in an amount which would have provided anesthetic gas enough to put the 15 members of their Board of trustees to sleep once a week for a month. It is rumored that a certain hospital charges $100 for membership on the staff and that one of its surgeons charges $150 for one leucocyte in an appendix. It is rumored that for membership in some specialities one sacrifices his freedom of action. Other voices say we have been "aginners" for so long we couldn't possibly be "for" anything. We are charged with stifling and impeding the expansion of prepayment, the development of public health, impeding progress in preventive medicine, limiting the number of doctors, yes even the proper interest in the medical care of the armed forces. We are allegedly anti-veteran care. Put these rumors all together and if we are not charged with being unethical from within, then we are accused of being immoral, dishonest, reactionary or resistive to change from without.

At this point I wish to remind you that I have just submitted hearsay evidence, and I have reported rumors. Where does that bring us? It brings us to the subject of my talk, namely, "What are the relationships of the Community and Hospitals to the Future Practice of Medicine?" And now I would like to state a few personal opinions regarding the future.

The trend in the last ten years which has developed a large body of third-party purchasers of hospital and medical care, who now pay nearly cost for hospital care, means that individuals and groups other than hospital trustees and medical staffs will have an ever increasing voice in the future of our programs. The outcome of the last presidential election should be ample proof that people will have their way, though sometimes it may not be *our* way—or even the better way.

I believe that medical care of the future, provided and protected by an alert and understanding body of American doctors, will be the best assurance of its high grade and progressive character for the American public. I believe that the opportunity for physicians to maintain such a spot in directing the destinies of American medicine will be possible only if we attack every existing weakness in our system and strengthen any area where weakness jeopardizes our position. Such areas will be identified only with an open mind and by a strength of character which will enable us to meet head on, within or without the profession, any problem or person not meeting our ideals and standards.

With the leadership given by Dr. Cline, Dr. McCormick, Dr. Martin and Dr. Bauer to the American Medical Association and the platform enunciated by Dr. Bauer, we have a road map to follow. A few years ago through the cooperative action of John Cline and myself an attempt was made to bring the American Medical Association and the American Hospital Association closer together in our common endeavors. As President of A.M.A., Dr. Cline was the first such President to address an A.H.A. convention. As President of A.H.A., I was the first to address the House of Delegates of the A.M.A. Since then the Joint Commission on Accreditation of Hospitals has been founded, following a year of the toughest negotiations I have ever participated in. The sincerity of the participants of the five national groups, and the single objectivity of interest in the patient, plus continually meeting, I believe has resulted in welding together the interests of doctors and hospitals for the betterment of patient care in a way never attempted before. For over two years, a Joint Committee of the A.M.A. and A.H.A. have worked together diligently, seeking a solution of other areas of concern between doctors and hospitals. Dr. McCormick in Chicago last year reported progress. I see in the future continuing improved relations in this area. Dr. McCormick in his talk said that there should be no room available for strife between doctors and hospitals. I firmly believe that this type of problem is one between doctors and hospitals and should not have to be settled by others in the community. It will, in my opinion, be settled if our Joint Committee continues to meet long enough to find areas of agreement even though it takes certain concessions on both sides. In my opinion, staff relationship problems concern only a very small percentage of doctors and will be finally solved when the entire body of the profession is willing to face up to them and support any agreement reached at the Joint Committee level. High-handed methods or sharp practices on either side should not be tolerated. The "Freedom of Contract" for the physician, in my mind, is as sacred as "Free Choice of Physician" for the patient. Our national groups in health activities should guard with all their might the rights and freedoms of their individual members. To save our freedom from government tentacles only to hand it over to creatures of our own creation appears to me to be a case of out of the frying pan into the fire. There must be some common denominator in ethics. Let's find that common denominator and set a Code of Ethics for doctors and hospitals which will make all parties proud of the word.

I foresee in the future the financial aspects of care assuming greater and greater proportions. In this area not only the doctor and hospital are involved, but also the community. Before discussing the details of finance I would like to outline my basic philosophy. It is futile to talk of spending less for the health care of our nation. We must spend more. Prepayment plans have given us the tools with which to do this job, and our only problem is how fast can we expand our service. We haven't begun to reach our potential and can truthfully be considered only tooling up for the job ahead. Louis

Lunborg of the Bank of American recently said: "Financing the future cost of education is no problem at all. At least it is no financing problem." He goes on to say that people who come to the Bank of America believing they have a financial problem usually have other problems—sales, production, or management problems.

So, too, in our field of health. There are those who would have us believe it is a problem of dollars. I do not believe this, nor do I believe health should be a matter of politics. In our dynamically expanding economy, where we have air conditioning as well as a billion dollar television industry, I believe it possible to budget for medical and hospital care without giving up lipstick for our wives, cigarettes for ourselves, or television for our youngsters. Our problem is not one of dollars, it is a problem of education. This education is needed by three groups—Doctors, Hospitals and the Public.

To deal first with the area of education for the profession, I should remind you that it entered prepayment reluctantly, only later to use it as one weapon against being swept into the basket of F.S.A. To read the Magnuson report and see the space given to voluntary prepayment and to realize the recommendation made concerning it, is concrete evidence that, even with the reluctant support of medicine in some areas, prepayment has arrived as a potent force. I would urge all doctors to take their tongues out of their cheeks on this matter, and start motivating those tongues towards its active support and intelligently phrasing recommendations to make it more and more acceptable to doctors and patients.

Further, active steps should be taken by doctors to prevent any abuse of this program. Here again it is only a vocal minority with specific axes to grind who bring criticism upon the entire profession. If there are abuses, let's identify them and try to correct them by education. If education does not work, then the profession, should police them. If, and I repeat, *if*, abuses do exist and the profession defaults in its responsibility of self-policing them, I am confident others will do that job. The S.E.C. failed to police their profession. The abuses resulted in a national catastrophe —the resulting regimentation and controls were more severe than would have been necessary if self-administered. A national catastrophe must not fall around the ears of Blue Cross and Blue Shield. Doctors have a moral responsibility to see that their patients receive as many tests as are honestly needed for diagnosis, as much hospitalization as is honestly necessary for therapy and as many office visits as good standards of practice require. Doctors also have a moral responsibility to the eighty million people covered in prepayment plans to see that their investments are closely guarded so that their dollars will buy the maximum amount of needed care at the lowest cost possible on a standard of fairness to all involved. The moral responsibility to a patient and the moral responsibility to the 80,000,000 are not inconsistent when men of integrity and courage make the decisions.

Prepayment plans have created some tensions between doctors and hospitals in some areas. Plans are helpless in pointing out or correcting possible abuses. Hospitals may be aware of possible abuses but are in no position or have no right to police or discipline individuals in this area. The medical staff of a mid-western hospital has assumed the responsibility of reviewing prepayment cases monthly and I am informed it is working well. I offer the suggestion that you try this method at the Greenville General Hospital for a trial period. I'm sure it is not necessary here, but it would be tangible evidence of your interest in answering criticism elsewhere, as well as setting an example.

The second area of education concerns the hospital. And here we need to take more tongues out of more cheeks. This movement was not a shotgun marriage. Blue Cross was the child of hospitals. We need better accounting methods to deal with this new method of financing. We need more scientific management to assure the public that costs are at an irreducible minimum, consistent with quality and high standards. It is not sufficient to prove a nonprofit status or even a loss status. The public is continually demanding reassurance that hospital costs do not include waster or

poor management methods, resulting in higher costs.

The public is the third area where education is needed. They need to know that a mere desire for lower costs is not logical. Money must be forthcoming to meet the honest labors of their physicians and the legitimate cost of hospital care. Anything less than cost will lower standards and result in an inferior product. There are no fire sales, 1¢ sales, January sales nor inventory sales in health care. They should learn that certain limitations exist in this infant program to safeguard its growth through adolescence. It is not geared to do the job of a man while still a boy. It doesn't cover everything. We in health know it doesn't. We are anxious to expand it, if and when it is timely to do so. We are aware of their desire for ambulatory care, dental care, visiting nurse care, convalescent care and catastrophic or long-term care. They should be assured that such problems are being explored and will continue to be studied for possible answers. When the public states that prepayment doesn't cover everything, they should be reminded that neither does the Bikini bathing suit—they were both designed to cover the essentials.

Lastly, prepayment groups should be urged to accumulate, correlate and analyze statistical data, towards the end that suggestions will be forthcoming for our consideration from time to time.

As I turn my crystal ball I see another area in which doctors, hospitals and communities should have a great interest, and that is medical education. Because of financial stresses, paucity of teaching material, and the difficulty in attracting and holding qualified faculty, I have some real fears for the future, especially for the private medical schools. Doctors have demonstrated an interest through the Educational Fund of the A.M.A. This is admirable and should be continued. Doctors could help even more by referring deserving patients in greater numbers to the teaching services of our medical schools, especially the private medical schools. Hospitals should become better acquainted with the problems of medical education, and should continually strive to improve and support to their utmost, sound programs for interns and residents. The community will always remain the source of funds for all our programs, but they should be made aware throughout the country of those needs in the field of medical education. Money is available and the public will invest in those programs they believe in, but first they must be sold.

And now my crystal ball is twirling so fast I can only call out the titles of areas of doctor, hospital and community action and let you ponder over them.

The problem of catastrophic illness.

The shortage of hospital personnel.

The shortage of nurses.

The problem of antiquated hospital structures.

The practicing doctor without a hospital appointment.

Who finances the cost of the medically indigent?

The place of the small hospital in the rural area.

I had a dream recently that I would like to relate to you. I sat before a movie screen and saw revealed the varying opinions of many regarding their conception of a great medical center.

First to appear was the Hospital Administrator who saw the increased headaches, the budgetary problems, the blood, sweat and tears of planning, the personnel shortages, the problems of staff organization, and as he wearily left the scene I knew he saw more problems than he described.

Next came a happy Board of Trustees who saw it as "mission accomplished." They remembered the labor pains, but now the child was born they rejoiced and forgot their sorrows.

Next came a group of Doctors — the inner circle — God's chosen. They saw it as a fine place to work in, but deep within their souls they saw it as a place for personal glory.

Next came a group of Doctors — not God's chosen, just God's humble men — who saw it as the gates of heaven closed to them. A place to be desired, but not attained.

They gave way to a third group of Doctors

—not God's chosen, not God's humble men, but just God's workmen. They saw it as a competitive enterprise. Just a place to give unfair advantages to their rivals.

Next a group of citizens who saw it as a beautiful piece of architecture and as they left the screen they whispered a prayer that they might never see it again.

And then from the pages of Dickens stepped Tiny Tim to tell me that I had been unfair in my interpretation of the concepts of the previous actors. So I asked him just what was a medical center like the Greenville General. As I sat back Tiny Tim started:

"This great medical center is a reflection of the past and the keystone of the future. The past is a story of great men down through the ages, who have made the relief of pain, the repair of the injured and the prevention of disease one of the noblest professions on earth. Out of the past has come knowledge that has made possible the golden age of medicine in which we live; the age of miracle drugs and miracle surgery; an age where the blind see, the deaf hear, the lame walk, and the lepers are cleansed. All these have been made possible because God in his wisdom had endowed men in the medical centers of the past with the mental powers to find the way. And there are many other marvels such as replacement transfusions, cancer detection, radio-isotopes, powerful x-ray, cyclotrons, linear accelerators, and cardiac surgery. But in the past, many of the parts were separated and isolated and men worked at great odds and without tools.

"But here in Greenville we now have in this medical center the fusion of all the parts to make the whole. We will see medical education going down the years ahead hand-in-hand with all the staff of this hospital. Humility will be present on all sides; singleness of purpose will be the order of the day. And that staff will be assisted by many unsung heroes in the form of nurses, dietitians, laboratory workers, social service workers and a host of others. This center will stand as a bulwark against disease in this area. Here its guests will receive expert help in all fields, complete equipment will be available, research will be a room-mate with diagnosis and treatment. Conferences, lectures, libraries, and rounds will be made available to physicians who wish for an opportunity for progressive improvement."

I said, "Sounds fine, what do you expect from it?"

He said, "Who knows—perhaps another golden age which will make our present one look tarnished. He mentioned, cancer, viral and mental diseases."

At this point I asked why I had ever stooped to mention such words as ethics, integrity, reactionary, fee-splitting, closed shop, etc.

He smiled as he limped away saying, "Tony, don't sell the medical profession short. They have their problems, but they have an outstanding record of service and accomplishment, and come back to Greenville when the century turns and you will see that they continued to produce."

IN VIVO EXPERIMENTS WITH CARCINOGENS. VI.

JOHN R. SAMPEY*

Previous survey by the author on *in vivo* experiments with carcinogens have covered more than 700 articles in the current medical literature.[126, 127] The present study reviews briefly another 150.

I. INORGANIC CHEMICALS

Radioiodine. Gorbman induced pituitary tumors in mice with high dosages of radioiodine.

Uranium. Hueper, et al, produced sarcomas in rats with injections and implants of uranium.

Irradiation. About 50% of the national deaths due to cancer in Bohemia were found among the miners of the Jackymov radium mines.[138] Folley, et al, reported a significant increase in the incidence of leukemia among survivors of the atomic bombings of Hiroshima and Nagasaki.

Radon. Neoplasms were induced in mice with radon seeds.[98]

Chromium. Gregorius reported lung cancer was 16 to 80 times more common in workers in 6 chromium producing companies in the U. S. than in the general population. Earlier Baetjer reviewed chromate-induced pulmonary carcinoma.

Iodine. Chronic iodine deficiency resulted in pituitary and thyroid neoplasms in aged rats.[13]

II. HYDROCARBONS

Methylcholanthrene. MC has been employed to induce a number of neoplastic growths in mice, rats, guinea pigs and chickens.[10, 11, 21, 30, 34, 45, 52, 56, 68, 77, 79, 96, 104, 111, 120, 123, 132, 137, 144, 145, 153]

Dibenzanthracene. This hydrocarbon caused sarcomas in guinea pigs and rats,[104] and sarcomas and carcinomas in mice.[52, 53, 54, 55, 79, 121, 136] DBA tumors have been cultivated in fertile hen eggs,[21] but it failed to produce neoplasms when implanted in the sinus of chicks.[106]

Benzpyrene. This hydrocarbon caused sarcomas in guinea pigs,[30] and sarcomas and carcinomas in mice.[52, 79, 124, 155]

Benzene. Three cases of chronic myeloid leukemia have been traced to benzene.[17]

Tar. Dervillee, et al, has filed two reports on tar cancers produced in workers.

Benzacridines. Both 5, 6-and 7, 8-benzacridines induced sarcomas in mice.[154]

Phenanthrenes. 1 - Methyl - 2 - isopropylphenanthrene was weakly carcinogenic.[152]

Dimethylbenzanthracene. Single applications of DMBA to the lip of mice caused hyperplasia of the epithelial cells.[87]

III. ORGANIC NITROGEN COMPOUNDS

Aromatic Amines. Naphthylamines induced bladder tumors in dogs,[134] and rodents [15, 16] The occupational hazards of workers handling naphthylamines has been recorded.[7] The carcinogenicity of dimethylaminoazobenzenes and related azo compounds has been the subject of a number of studies.[22, 33, 63, 86, 101] Pure aniline hydrochloride did not induce tumors in rats.[40]

Aminofluorenes. AAF is a strong carcinogen.[56, 67, 93, 122]

Urethane. Pulmonary tumors have been produced in mice with urethane.[5, 18, 140] Meacham, et al, described liver damage in a patient after prolonged urethane therapy.

Pyridoxine. This agent increased MC fibrosarcomas in rats.[45]

Mustards. Both nitrogen and sulfur mustards caused a number of different neoplasms in mice.[65]

Carbamates. Carbamates were more carcinogenic to mice than urethane.[66]

Thiouracil. Mice fed propylthiouracil developed thyroid and pituitary tumors.[100]

Ethyleneimines. Substituted ethyleneimines induced lesions similar to those from mustard therapy.[147]

Histamine. This chemical caused hyperplasia of the forestomach in mice.[150]

Benzidines. Feeding dihydroxy-benzidine to

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rats produced hepatomas, carcinoma of the colon and other neoplasms.[4] Benzidine accounted for 13 neoplasms in one plant over a 17 year period.[7]

IV. HORMONES

Estrogens. Three reports described the formation of uterine carcinoma in patients after prolonged estrogen therapy.[108, 109, 149] Carole, et al, reported one patient developed cancer of the liver following implantation of estradiol benzoate. Novak presented the hazards of estrogen therapy, but Dunn reported no neoplasms after twenty years of therapy with large doses of estrogens.

Korenchevsky reported more neoplasms of the pancreas, liver, adrenals and other organs of older rats following the administration of estrogens than he observed in younger ones. Estrogens also produced neoplasms of the pituitary in rats[96] and fibromas in female guinea pigs.[103] Estrogens increased leukemia in male mice from 41.5% to 71%.[105] Female sex hormones also increased the incidence of sarcomas in rodents following irradiation,[77, 104] and the mortality of irradiated mice.[85] Klein observed that fibrosarcoma transplants grew better in female rats.

Androgens. Androgens also induced more neoplasms in older rats.[80, 81] Gonadotropic hormone enhanced the formation of tumors in intrasplenic grafts,[156] and it increased lung tumors in x-irradiated mice.[85] Leukemia developed earlier in castrated male mice.[1]

Cortisone. This hormone increased the incidence of MC tumors[69, 146] and of benzpyrene tumors.[130] Sarcoma I in mice were made to metastasize by subcutaneous injections of cortisone.[91] Mice injected with desoxycorticosterone developed sarcomas.[99]

V. MISCELLANEOUS

Occupational Hazards. Attention has already been directed to the hazards in the handling of industrial chromates,[3, 58] tars[35, 36] benzene,[17] naphthylamines and benzidines.[7] Schlegel studied the incidence of cancer in arsenic plants and others have investigated the risks in the oil industry,[73, 84] and the dye industry.[28, 133] Hueper investigated commercial carcinogens in the air polution, while general reviews of occupational cancer have been made by Gross, and Mayers.

Smoking. The relation of tobacco smoking to the incidence of lung cancer has received further investigation.[29, 38, 39, 42, 72, 119, 141, 151]

Dyes. Subcutaneous injections of three food dyes caused fibrosarcoma in rats,[107] and lymphosarcoma have been observed in rats after vital staining with Trypan blue and Evan's blue.[92]

Plastics. Oppenheimer, et al, caused sarcomas in rodents by implants of commercial plastics.

Diet. Diets of 15 to 25% tributyrin produced gastric lesions in rats.[125] A low casein, high fat diet accelerated the carcinogenic action of tannic acid.[83] Several fatty acids in the diet of rats caused gastric lesions.[102] Vitamin B_{12} markedly increased the carcinogenicity of DAB in rats on a methionine-deficient diet.[33] Increase of vitamins A and C caused an increase in estrogen-induced fibromas in guinea pigs.[103] Low vitamin C diet had no effect on the growth of S-37 tumors in guinea pigs.[43]

Folic Acids. Folic acid caused the complete reversal of aminopterin-induced inhibition of S-180 in mice.[49] 4-Amino-N^{10}-methylpteroylglutamic acid induced lesions in rodents and dogs similar to those by 4-amino-PGA.[46]

Fluoroacids. Several fluorine substituted acids increased Guerin tumors in rats.[135]

Tannic Acid. Korpassy, et al, studied the carcinogenesis of tannic acid.

Cottonseed Oil. Black tar from heated cottonseed oil failed to induce tumors in mice.[25]

Enzymes. Mucin and hydluronidase injected in chickens promoted the growth of sarcomas.[48]

Alkaloids. Senecio alkaloids, other than *Senecio Jacobaea,* induced liver tumors in rats.[131] Alpha- and beta-longilobine both produced severe liver injury.[64]

Agar. Subcutaneous injections of agar-agar caused granuloma in rats.[2]

Urine Extracts. Bergman caused neoplasms in mice by injecting urine extracts from a patient with cancer, and Bassi noted that a combination of urine extracts from cancer patients and MC resulted in many more tumors than either agent produced alone.

Tumor Agent. Further investigations have been made on the mammary tumor agent.[6, 12]

Antibiotics. Aureomycin hastened the development of Walker carcinoma, but terramycin did not.[27]

Infections. Brown recorded that 4 cases of acute leukemia were complicated by chronic sinusitis. Ishihara isolated gram-negative bacteria from the blood of cancer patients, which injected in mice induced neoplasms.

Virus. The virus origin of certain neoplastic growths has been investigated.[51, 89, 90, 97, 112]

Cells and Tissues. Human neoplasms have been transplanted into experimental animals.[57, 89, 90, 148] The effect of freezing and drying cancerous tissue before transplantation has been studied repeatedly.[14, 24, 37, 44, 117, 118] Papilloma have been transplanted into monkeys[88] and horses.[26, 113] Extracts of leukemic cells caused cancer in mice.[60, 61, 62, 143] Injections of cells of chickens with lymphomatosis resulted in transmission of neoplasms.[20, 31, 32] Fibrosarcoma also have been transplanted in rodents.[78, 142] Kaliss, et al, injected lyophilized Sarcoma I and spleen of mice prior to implantation of S-I to break down the resistance to the grafts. Grafts of the anterior hypophysis or ovaries transplanted into orchidectomized mice developed lymphoid tumors.[139] Injection of lyophilized normal mouse tissue promoted the growth of adenocarcinoma 15091a,[75] and injection of spherical particles of 200A to 1200A diameter caused tumors in 56% of 221 mice.[116]

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Note—An alphabetical list of references may be obtained upon request to the Editor of this Journal.

INDUSTRIAL DERMATOSES

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Within the past fifty years, industrial dermatitis has become a problem of great economic importance. The need for a program of recognition and treatment of these conditions has steadily grown in company with the remarkable and continuing industrial expansion of the new South. Industry has been migrating southward for years. New factories and production centers have sprung up all over our section of the country. With reasonable availability of labor and of sufficient water supply for large industrial users, South Carolina may count on much further accelerated expansion in the years to come. Along with the augmented industrial activity will come greater exposure of workers to chemicals and other irritants as well as primary injuries incident to all types of work. Proper management of exposure, prevention and removal of hazards, and proper care of those accidents and dermatoses which arise in spite of all efforts at prevention will be a keystone in the economic structure now being formed.

Even in 1951, 1% of all American workers developed some dermatitis in connection with their work and the annual loss from dermatoses in that year was well over $1,000,000.00. This figure does not include losses from other occupational accidents and compensable injuries. To establish a dermatitis as being occupational, the worker must not have had the trouble before starting the work engaged in when the condition developed. He must also have developed the condition while at work and, further, must have been at work under suitable circumstances so that reasonable exposure may have taken place. Furthermore, the occupational insult to the skin must be shown to be the major, if not the only, cause of the trouble.

We must also differentiate industrial accidents which are primary injuries of the skin from occupational dermatoses which develop rather slowly over a period of time after

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reasonable exposure. The factor of time here is the major one in interpretation.

Only 5% of all compensable cases are due to illness. The rest are injuries and trauma. But of this small 5% group, 65% are occupational dermatoses and of these, 85% are primary irritations or injuries. The remaining 15% of cases are more likely to fall in the sensitization or allergic class and this group gives rise to most of the difficulties in determining liability and compensability. It is this group also which at the present time is excluded more or less in South Carolina from coverage by the compensation laws.

The group of occupational dermatoses may be further broken down into subclasses. 42% of the total are due to primary irritants which by definition are strong enough to cause dermatitis in a normal skin after exposure for a reasonable length of time. These include solvents, gasoline, paint thinners, acids, alkalies, chromic and sulphuric acids, cements, creosote, tars and formaldehyde, pickling brines, and insecticides. Another group of 23% are due to trauma and accidental injuries such as cuts, bruises, thermal and caustic burns, secondary infection of other injuries, OVERTREATMENT and reactions to treatment such as penicillin reactions.

The group of contact sensitization dermatoses constitutes 14% of the total. Repeated exposure is necessary, and the dermatitis is usually proportionate in severity to the degree of exposure. Common causes are nickel, rubber, phenols, sensitization to drugs used in treatment such as furacin, sulfas, *local anesthetics* including most of the "caines", sulfonamides inside and out, and penicillin.

Another group of 11% are due to soaps and detergents. Volatile solvents (used by painters, and machinists), soaps and the newer cleansing and washing powders, and solutions bother bakers, foodhandlers, and maids.

It is important in every case to establish a proper diagnosis, both from the standpoint of the recovery of the patient and also in regard to compensability. The history should show no antecedent eruption of the kind under consideration. The patient must have developed the dermatitis while at work after reasonable exposure. The distribution must be sufficiently characteristic to indicate the areas of contact. The clinical type of dermatitis often is of help in making the diagnosis. Lastly, patch tests may be used to confirm the diagnosis.

Pre-employment patch testing has been advocated but is not reliable. The lack of reaction does not mean that the patient will not develop trouble later at work. The test itself may even sensitize the patient to the chemical before ever being exposed at work. The patch test must also be done properly. As closely as possible, the contact conditions of the occupation should be duplicated. The chemical should be diluted to working strength or to a dilution as set forth in tables published for this purpose indicating a strength which is not primarily irritation to any normal skin. The chemical in proper dilutions is rubbed on or soaked into a small square of blotting paper, this is placed on the skin and covered with adhesive tape. The patch is usually left on the skin for 48 hours, and then the skin is examined for redness and blistering. Expert interpretation is usually necessary in connection with contact testing.

Treatment must be judicious and above all *not too strong*. Many, sometimes even a majority, of the dermatoses are subjected to such powerful or sensitizing treatment with strong keratolytic salves and itch-stopping caines (derivatives of novocaine, etc.) as well as topical antihistaminics, topical antiseptics, etc. that the OVERTREATMENT phase rapidly obscures and overpowers the original dermatitis. Mild soothing treatment, except in the face of a fulminating infection, is always to be preferred both in safety and efficacy. Open wet compresses are best in the acute phases. They will soothe and dry an angry wet skin better than anything else. The simplest is normal saline solution made by adding 1 teaspoonful of ordinary table salt to a quart of water. Aluminum acetate solution (Burow's) in the form of Domeboro tablets or powder or Burosol Antiseptic powders are mildly astringent and also helpful. Potassium permanganate (5 grains to a quart of water) makes a drying and most acceptable preparation but turns the

skin brown.

After the eruption is dry and less red, an all-purpose liniment is much to be preferred to all of the lotions available.

BASIC BUROW'S EMULSION
(Liniment)

Zinc oxide pdr	15.
Talc	15.
Anhydrous lanolin	15.
Olive oil	60.
Alumin. Acetat. Sol	3.
Tween 80 (Sorbitan)	3.
Aquae Dest q.s.	150.

Mix powders first, add lanolin and oil. Rub up well in mortar. Add Burow's, Sorbitan and water. Emulsify with Mixmaster.

May add 1% phenol, ¼% menthol, mild antiseptics if needed.

Lotions are drying and tend to cake rapidly. Pastes and ointments are too inclusive and cause heating and maceration. The liniment shown in the illustration is a most reliable standby in any stage of inflammation up to the endpoint of healing when the official cold cream is most acceptable for the final stages of healed irritability while the skin is settling back down to normal. Strong antiseptics do more harm than good. Strong local antipruritics and anesthetics are no more helpful than the wet compresses and the liniment given above and infinitely more dangerous to use. If there is infection, give antibiotics internally in most instances and not on the skin itself.

Perhaps even more important than all the foregoing is the problem of prevention. In hiring workers, the candidates who already have a dermatitis or who have a seborrheic habitus (severe dandruff of scalp, scaling behind ears, on the face, about the nose, and on the sternum) or who have an allergic background with asthma, hay fever, or eczema either in themselves or in a strong family inheritance, should be considered carefully in the light of the increased risk they present. They are much more likely to develop trouble than normal persons. However, they should

Cement Dermatitis

be perfectly capable of handling work which does not entail chemical or irritant exposure, such as selling and clerical jobs.

Harsh soaps and detergents should not be available at the places of work. Satisfactory substitutes are easily available and at very little increase in cost. This precaution will pay for itself many times over.

Where irritating chemicals have to be handled in the very nature of the work itself, protective clothing, avoidance of prolonged exposure, proper washing and cleansing before and after work, and the use of siliconized protective films will be well worthwhile and should be a carefully worked out part of the industrial program. Just as important is the necessity for frequent and constant observation by a trained supervisor, whether a physician or otherwise. Human nature is in itself a chronically careless leave-it-'til-tomorrow kind of thing. Constant, but considerate, reminding and seeing that proper precautions are taken

is absolutely necessary. No amount or number of signs tacked on the walls and totally disregarded by the average worker, can take the place of a pleasant interested friend whose job is to help the worker protect himself from untoward incidents.

The average age of much of the population is rising into the forties and fifties, both because of better nutrition and living standards, and because of the preservation of life by the newly discovered antibiotics. Because of this, another predisposing problem begins to appear. This one is often neglected and is not yet fully understood but it is becoming very important indeed. Older workers may develop stasis dermatitis on the basis of varicose veins which become worse with age. After years of chronic dermatitis of the lower part of the leg, there develops an autosensitization of the whole body with the ulcer or dermatitis of the leg acting as a focus of infection. The result, if not a frank dermatitis of the thighs, hands, forearms, face, and finally the body, is a definite lowering of the vitality and resistance of the skin in these areas, rendering them much more susceptible to any mild irritation which would not bother a normal skin but is sufficient to deliver damaging blows to the skin in these subnormal areas. The role of stasis in chronic industrial cases is a point to be kept in mind.

The status of the allergic or sensitized individual with occupation dermatitis is at present a somewhat unfortunate one. His trouble in most cases is not compensable, even though it has arisen from his occupational hazards. The subject has two sides. If all allergic dermatoses were made compensable, the question of making the diagnosis and proving a connection with the occupation would be a most formidable one and would call, in many instances, for expert interpretation by a disinterested and impartial observer after much tedius testing and study. The dermatitis might have arisen independently of the work. These borderline cases need a thorough study and a review of their relationship to the industrial laws of the state. Perhaps eventually, an equitable revision of the laws and their interpretation may resolve the situation so that no hardships result.

Finally the problem of the chronic occupational dermatosis which fails to clear up sometimes faces us. The patient may be enjoying his compensable status, he may be making as as much as he did when working, and may have learned through the patch testing studies how to use the chemical to which he is sensitive on his own skin in such a way as to perpetuate his vacation from work. Sometimes he fails intentionally, or unintentionally from failure to understand instructions, in keeping up proper treatment. He often adds his own home remedies to clutter up the situation or may even take treatment from several physisicians at the same time, without one doctor knowing about the others. Secondary infections may complicate the eruption and often OVERTREATMENT complicates both dermatitis and infection. Unwitting exposure at home to similar irritants or detergents may also play a part.

With further study of the situation, a review of the laws in order to bring them up to date in keeping with a constantly changing industrial status, and with an enlightment and cooperation of employer, employees, industrial health workers, and physicians as well as the insurance carriers concerned, a pleasant and mutually workable solution of the problem is quite possible.

Editorials

THE SOUTHERN MEDICAL ASSOCIATION

It seems that at times South Carolinians have been more prominent in this excellent organization than they are now. Except for our Councilor, W. Thomas Brockman, and our Councilor-elect, J. W. Jervey, Jr., there appears to be none of our names in the list of officers and chairmen. The next meeting should give us an opportunity to rectify this situation. Let us hear the Councilor, speaking in the *Bulletin* of the Southern Medical Association.

My Dear South Carolina Doctor Friends:

We have fourteen hundred members of the South Carolina Medical Association. We have the same number as members of the American Medical Association. The Southern Medical is the second largest general medical association in the United States—a southern institution—and we are very proud of its past record. The Houston meeting will be the 49th session.

There are 300 South Carolina members. When we realize $10.00 pays our membership and brings to us one of the best medical journals that comes to our desk. I believe we can enlarge our membership to 700. Doctors of the South Carolina Medical Association had a big part in founding the Southern Medical Association. You will say there are so many specialty groups that I just cannot join any more medical societies. I urge every one of you to consider attending the Houston meeting, November 14-17th.

Along with these membership privileges, you are eligible to take special hospital and disability insurance at a very attractive annual premium.

Hoping to see the largest attendance we have ever had in Houston in November, I am very humbly

Your Councilor,
W. Thomas Brockman, M. D.

THE DRAFT STILL BLOWS

The extension of the Doctor Draft was "received with regret" some time ago. Its approval by our legislators does not lessen its unjust and discriminatory character. While the armed services are making some effort to reduce the need for such legislation, it will probably not make much headway as long as an acquiescent Congress continues to make a supply of physicians readily available without sound consideration of needs.

BASHFUL RADIOLOGY

Radiology has always seemed to enjoy popularity, reasonable prosperity, and sincere respect from the medical profession. Rather than being unappreciated by the public, it has often been expected to perform beyond its limitations. Witness the patient who wants to be "x-rayed" from head to foot in the expectation of a rapid revelation of all the ills which he has acquired, and witness furthermore the hope and faith in the therapy of malignant disease.

Now why in the name of Wilhelm Konrad Roentgen should radiology need a campaign of exploitation to the public, and why should the American College of Radiology employ the J. Walter Thompson Company, top notch publicity agents, to expound to the public the importance of radiology and the wonders which it may accomplish? A "fact sheet", from the company contained in a handsome folder embellished with pictures of roentgenograms surrounding a smiling family of eight, who obviously have just been "x-rayed", gives an outline of the things readers of magazines should know about the virtues of the use of the x-ray, and is to be followed by more information of the same kind.

If this is the proper kind of general advertising for a branch of the profession, we may expect with misgivings similar campaigns which will carry to the eager and ignorant public accounts of the virtues of urology,

plastic surgery, internal medicine, gynecology, pediatrics and so on to the end of the list. Perhaps this is the modern way to establish good relations, but it seems a bit removed from the conventional approaches.

VENERAL DISEASE MORBIDITY REPORTING BY PRIVATE PHYSICIANS

During the past decade much has been said and published concerning the phenomenal success obtained in the control of the venereal diseases and there is no questioning the fact that the incidence of these diseases has been declining. Factual data on trends, however, is based upon statistical information received from all sources. These sources might be arbitrarily divided into two groups—reports from organized Health Agencies, and reports from private physicians. In the latter case, unfortunately, there is still room for considerable improvement, and the cooperation of all private practitioners concerned is earnestly requested.

Reports from over the nation indicate that 44% of all the venereal diseases are reported by private doctors, and in some states as many as two-thirds of the cases are reported by the private physicians, whereas, in South Carolina only 2% of all venereal disease cases are reported by private physicians.

It is only by conscientious reporting by private physicians that an accurate picture of the extent of the problem may be obtained, and the epidemiological and statistical importance of pin-pointing incidence by area should be obvious.

It has long been realized that the private physician plays a vital role not only in the treatment, but in the actual control of the venereal diseases, and it is only by reporting his cases that he can be given the recognition due him for the valuable contribution being made in this public service.

It is believed that much of the reluctance exhibited by private physicians in South Carolina in the reporting of their venereal disease cases may be due to the erroneous belief that they must report these cases by name. While it is true that on the Venereal Disease Morbidity Report Card there is a blank space for the name, it is not necessary to fill in this space. *The name of the patient is NOT required.* The information desired is used only for statistical purposes. The more information furnished (other than the name) the more valuable it will be for statistical use.

Early in August 1955 a plan was worked out jointly by the V. D. Control Section of the State Board of Health and the Division of Laboratories, whereby each positive serological report for syphilis returned by the laboratory to the private physician is accompanied by a Morbidity Report Card, with the request that it be completed with especial reference to stage of disease and returned in a franked envelope to the Tabulating Unit. The information from the serology report is forwarded to the physician and the name-space on the morbidity report card is blanked out so that there cannot possibly be any violation of confidence. The physician is merely asked that if a diagnosis of syphilis is made he indicate the stage of disease then detach the card and drop it in the franked self-addressed enclosed envelope. In return for the service of serological testing without cost any and all specimens the physician send in, it appears that this is indeed a small request.

BLUE CROSS . . . BLUE SHIELD

For more than a year audits have shown that the experience of our Blue Cross and Blue Shield plans has been unfavorable. Both plans lost money and depleted, to some extent, their reserves in 1954. Blue Shield was still solvent and not in serious condition, Blue Cross, however, was in serious difficulties.

Blue Cross had increased its membership dues during the year, with little change in its condition. Near the year's end, a cooperative payment, amounting to the cost of room and board during the first two days in hospital, was required of all hospitalized members. This requirement proved to be a life saver, and improvement in experience was almost immediate.

Blue Shield felt that it would be unwise to increase

membership dues without first some other effort to decrease its expense. Some non-contractual benefits were discontinued, and there were some adjustments in the schedule of fee allowances. Further, there was a scaling downward of the payments to Blue Cross for administrative expenses.

Audits for the first quarter's operations this year showed definite improvement. On May 1, Mr. Allen Howland resigned as executive director of both plans. The Blue Cross Commission was appealed to for technical assistance. A team of expert trouble shooters were sent to South Carolina to study the situation and to make recommendations. This team reported that the most important cause of our troubles lay in the matter of underwriting—that is, the acceptance of group subscribers where the group participation was less than required safe percentages, the continuation of groups which had fallen below these percentages, and the acceptance of non-group members who were undesirable risks. Other bad or unwise practices discovered were matters of office management and administration. The Blue Cross Commission, at the request of our Blue Cross Board, sent us Mr. Robert Koch, assistant executive director of the Michigan plan, to be interim acting executive director of our plans. He assumed charge on June 1.

Under Mr. Koch's direction, there was accomplished a reorganization of the internal administration, steps were undertaken to bring all groups up to required strength or to break up groups which could not be brought up to par and to convert their members to the non-group category. Member hospital contracts have received intensive study and have been rewritten, and all member hospitals have been placed on a uniform basis in so far as the handling of their claims is concerned.

Mr. Koch returned to Detroit about August 1. He had done a magnificent piece of work for our plans. He had displayed remarkable energy, a wide knowledge and understanding, and a magnificent ability to organize and to delegate work and responsibility to selected members of the organization. Much that he did will be permanently helpful.

The plans have been fortunate in securing a permanent executive director. Mr. William Sandow, Jr. came from the Rochester, New York plan. He reported for duty on August 15. Because of a remarkable liaison between him and Mr. Koch, he was able to continue where Mr. Koch left off.

The next big task is to study the Blue Cross and Blue Shield contracts and to rewrite them in unambiguous terms, so that they will provide those coverages desirable and exclude undesirable or impossible coverages. After this is done, there will follow a study of membership dues in relation to the benefits provided in the contracts. This study will require actuarial consultation. The aim is to write Blue Cross and Blue Shield contracts which can be guaranteed for at least a year after issue with a guaranteed rate for the same period of time. When the Blue Shield contract has been rewritten; the fee schedule will be restudied, with the expectation that fee allowances for certain services can be made more realistic. The latter will require probably a raising of the present $150 maximum to $200. These several measures, when effective, will do much to remove the atmosphere of uncertainty and dissatisfaction which has developed in our state regarding both Blue Cross and Blue Shield.

These experts, who have worked with us and who have had long and wide experience in the Blue Cross - Blue Shield movement, have studied our potentialities in South Carolina. They are in unanimous agreement that our opportunities are tremendous and that the future of our plans is bright. Good underwriting, aggressive selling and top grade management, along with the constant and enthusiastic support of our doctors and our hospitals, will bring our hopes to fruition.

J. Decherd Guess
Medical Director

NEWS

Dr. Paul H. Garrison is associated with Dr. S. Darby Pendergrass, Jr., in the general practice of medicine in Greenwood.

Their offices are in the Medical Arts building on Spring Street.

Dr. Garrison is a native of Gaffney. He served in the Navy for 46 months, from 1942 to January 1946. He is a graduate of Wofford College and the Medical College of South Carolina and has just completed his internship at Spartanburg General Hospital.

Dr. George L. Irwin of Chester whose two-year tour in the Air Force terminated June 25, has opened his office for the practice of medicine at 208 North Street, Sumter.

Capt. Irwin completed his premedical training at Duke University and received his M. D. degree at the Medical College of South Carolina. He served his internship at the Cincinnati General Hospital, Cincinnati, Ohio.

Dr. William Atmar Smith, professor emeritus of medicine of the Medical College of South Carolina addressed the Columbia Medical Society in the chapel of the South Carolina Sanatorium at State Park.

Dr. Smith, who spoke on "The Solitary Pulmonary Lesions," is director of the Charleston County and the State Tuberculosis Associations, vice-president of the State Tuberculous Association, chief of the tuberculosis division of the Veterans Administration of the Southeastern area, a member of the South Carolina and American Trudeau Associations and a member of the board of directors of the South Carolina Sanitorium.

He has been medical director of Pinehaven for many years.

Dr. Robert M. Johnson, 1954 graduate of the Medical College of South Carolina, has opened an office in Riverland Terrace, Charleston, for the practice of medicine.

Dr. Johnson interned at Indiana Methodist Hospital in Gary, Ind. He is a native of Greenville, and attended the University of South Carolina.

Dr. James Guy Norris, Greenville, S. C., native, has opened an office on Main Street in Crescent Drive, Myrtle Beach.

Dr. Norris received his B.S. degree from Clemson College, his M.D. from the Medical College at Charleston, and interned at Watts Hospital.

Dr. James B. Pressley has joined Dr. Samuel H. Fisher in the practice of radiology with offices at Greenville General Hospital. Dr. Pressley is a graduate of Erskine College and received his M. D. degree from Vanderbilt University in 1942.

Dr. James Arthur Underwood, Jr., a native of Greenwood, has opened an office there for the practice of medicine.

He graduated from the Naval Academy at Annapolis in 1942, and graduated from the Medical College of South Carolina last June. He completed his internship at Greenville General Hospital July 1 of this year.

Dr. W. Atmar Smith, for 21 years associated with Pinehaven, has resigned as medical director of the Charleston County tuberculosis hospital.

The hospital's managing board has named Dr. David B. Gregg, formerly associate director, as Dr. Smith's successor.

THE MONTH IN WASHINGTON

Washington, D. C.—Although very little health legislation actually was enacted in the first session of the 84th Congress, a number of important bills made enough progress to insure they will get serious consideration when the second session starts next January.

Foremost is a bill to amend the social security act, and, among other things provide OASI payments for disabled workers after age 50. The present provision (enacted in 1954) protects a disabled worker's pension so it is not decreased because of his years of unemployment, but payments don't begin until he reaches 65.

The new plan, sponsored by Democratic members of the House Ways and Means Committee, was rolled through the House after closed committee hearings. But when it got to the Senate, Chairman Harry Byrd of the Finance Committee held it up, saying it was too important to be reported out without the complete hearings he plans for next session.

The American Medical Association is flatly opposed to cash disability insurance. One important reason is the Association's conviction that federal machinery necessary to regulate disability examinations inevitably would project the government into the medical care field. There are many other reasons, including the relationship between cash payments for disability and the patient's interest in rehabilitation. The issue of disability pensions will be settled next year in the Byrd Committee or on the Senate floor.

A bill for $90 million in grants for building and equipping non-federal research facilities passed the Senate, and is awaiting action in the House Interstate and Foreign Commerce Committee. Hearings have been held on a bill for U. S. grants to medical schools and on another (Jenkins-Keogh) to allow self-employed persons to defer income tax payments on part of their income put into annuities.

Other bills that will be ready for action in January include legislation to stimulate nursing education, improve the medical care of military dependents, authorize health insurance for government workers, authorize U. S. guarantee of mortgages on health facilities, and offer military medical scholarships. The administration's bill for reinsuring health insurance plans by now is a little shopworn, but it still might be pushed again next year.

President Eisenhower has made it known he wants Congress to get to work on health legislation early next session. His urging might not be needed. Next year is a presidential election year, and both parties will exert themselves to enact, and take credit for, new health programs that carry public appeal.

Despite the hundreds of hours of hearings in Senate and House, not a single important medical program was set up by Congress in the last session. A national health survey, supported by the AMA, was enacted, but the administration's plan for mental health grants will be up for action next year.

Ignoring protests of physicians and dentists, Congress extended the doctor draft act for another two years, after first adopting two amendments. It exempted all men over 45, and all 35 or older who previously had been rejected for medical commissions for physical reasons alone.

For almost four months Congressional committees pondered what to do about Salk poliomyelitis vaccine. At first there were two main questions: 1. How much money should Congress spend to buy vaccine for free shots, and who should get them? 2. How far should the federal government move into the picture to insure equitable allocation?

One of the proposals—this even got through the Senate—was to offer unlimited money to the states, which in turn could give free shots to any persons or group of persons under age 20. President Eisenhower's idea—which he urged on Congress several times—was simply to insure that no person in need of the vaccine would go without it for financial reasons.

Eventually his view prevailed and the states now are drawing on a $30 million fund. This law expires next February 15.

As weeks passed, there was less and less enthusiasm for setting up a federal allocation system, which Secretary Hobby and Surgeon General Scheele repeatedly told Congress wasn't needed. Consequently, when the National Foundation announced it had all the vaccine it needed for its program, a voluntary allocation plan was put in effect. The plan has the support and cooperation of physicians, pharmacists, drug manufacturers, and the state health officers. The Department of Health, Education, and Welfare is the liaison between the pharmaceutical houses and the states, dividing the vaccine on the basis of the number of unvaccinated persons in the eligible age groups.

From Washington Office
American Medical Association

POLIO VACCINE

Minutes of Meeting of the State Advisory Committee of Distribution of Poliomyelitis Vaccine
July 20, 1955

The State Advisory Committee for the distribution of poliomyelitis vaccine met at the Columbia Hotel at 12:30 P. M. on July 19, 1955.

Those present at the meeting were: Dr. William Weston, Jr., Dr. W. M. Hart, Dr. J. M. Albergotti, Mr. Ross Langdon, Mr. John Davis, Mr. J. C. Holler, Mr. B. B. Leitzey, Dr. G. S. T. Peeples, Dr. T. W. Wyatt and Dr. G. E. McDaniel.

Dr. Peeples opened the meeting with a discussion of the purpose of the State Advisory Committee and read a communication from Governor Timmerman designating him as State Liaison Representative between the State Advisory Committee and the National Advisory Committee.

Dr. McDaniel discussed the present status of the vaccine and gave a brief resume of the proposed allocation by priority groups for S. C.

Dr. Hart presented some recent developments in regard to designation of priority groups from information he had from Dr. Julian Price, a member of the National Advisory Committee. All members partipated in a rather free discussion of the allocation and distribution of the vaccine during the anticipated necessity for control. It was the general feeling that the State Advisory Committee should follow as far as possible, the recommendations of the National Advisory Committee.

After careful consideration and in view of the fact that at the present time no public funds are available with which to buy vaccine, the Committee adopted unanimously a motion made by Dr. Hart and seconded by Dr. Weston that all vaccine not purchased with public funds shall be distributed by the manufacturer concerned, by their regular methods of distribution, and/or through the licensed and regular wholesale drug distributors serving the state, subject to the approval and control of the South Carolina Health Officer to insure complete and equitable distribution, so that all counties in the state will receive a proportionate supply of each shipment of the vaccine. The concerned manufacturer or manufacturers shall furnish the State Health Officer a listing of the proposed recipients and addresses, and quantities of all vaccine to be shipped. Upon approval, the South Carolina State Health Officer will authorize the manufacturer or manufacturers to proceed with the distribution.

Discussion with respect to reporting on the distribution of vaccine in S. C. followed and it was unanimously adopted on motion by Mr. Ross Langdon, seconded by Mr. John Davis, that weekly reports be made to the State Health Officer on a form, to be supplied by the State Board of Health, by the wholesale druggist and the retail druggist. At this point the Committee wished to emphasize that poliomyelitis vaccine is prohibited by federal and state law from being distributed except on prescription.

It was moved by Dr. Weston and seconded by Dr. Albergotti that physicians administering poliomyelitis vaccine follow the recommendations of the National Advisory Committee on the administration of the vaccine by adhering to the designated priority age groups during the duration of the designated priority and that they keep a record in their office of the name, age, sex, race and address of the individual vaccinated, dates of inoculation, the manufacturer of the vaccine and the lot number of each inoculation. This motion was unanimously adopted by the Committee.

It was moved by Mr. Leitzey and seconded by Dr. Hart that "parents are requested to cooperate in the voluntary control plan of distribution and use of poliomyelitis vaccine by presenting to physicians for inoculation only those children in the designated priority group for the duration of the designated priority."

There being no further business the Committee adjourned at 3 P. M.

SOUTH CAROLINA PLAN FOR THE VOLUNTARY CONTROL AND DISTRIBUTION OF POLIOMYELITIS VACCINE

STATE AGENCY

A. The State Board of Health is the responsible State Agency for the poliomyelitis vaccine program. The State Health Officer was made the State Official as Liaison Officer between the State and the National Advisory Committee in the voluntary control program. The telegraphic delegation for this authority is: "Mrs. Oveta Culp Hobby, Secretary, Department of Health, Education and Welfare, Washington, D. C., In regard to your message of April 26 I have designated Dr. G. S. T. Peeples, State Health Officer, Columbia, S. C. as our State Official for the Advisory Committee to contact concerning distribution of the Salk Vaccine. George Bell Timmerman, Jr., Governor."

B. (1) The manufacturers will furnish the State Health Officer with copies of invoices of

all poliomyelitis vaccine shipped into the State.

(2) All Pharmaceutical Distributors of vaccine in S. C. will report to the State Health Officer weekly on a form provided, listing the date, name and address of purchaser, manufacturer, lot number and number of cc's sold.

(3) a. All vaccine purchased with public funds will be distributed to the counties in the proportion that that county's population bears to the total population of the State.

b. All vaccine not purchased with public funds shall be distributed by the manufacturer concerned, by their regular methods of distribution, and/or through the licensed and regular wholesale drug distributors serving the state, subject to the approval and control of the South Carolina State Health Officer to insure complete and equitable distribution, so that all counties in the state will receive a proportionate supply of each shipment of the vaccine. The concerned manufacturer or manufacturers shall furnish the State Health Officer a listing of the proposed recipients and addresses, and quantities of all vaccine to be shipped. Upon approval, the South Carolina State Health Officer will authorize the manufacturer or manufacturers to proceed with the distribution.

c. It is expected that the normal commercial distribution by the distributors of the vaccine in S. C. will equitably distribute it to all parts of the State.

Manufacturers will be provided with a list of counties in S. C. showing a percentage that that county's population bears to the state population as a guide for equitable distribution.

C. The Division of Disease Control of the State Board of Health will be responsible for the administrative details in the operation of the program.

D. No special, Health Department, or school immunization clinics are planned by the agency prior to the beginning of the school session 1955-56. All immunizations from available commercial vaccine will be given in private physicians' offices.

E. The State Advisory Committee unanimously agreed to follow the recommendations of the National Advisory Committee in regard to adherence to priority age groups.

STATE ADVISORY COMMITTEE

The State Advisory Committee is composed of the following:

Dr. William Weston, Jr., Columbia, S. C., Practicing Pediatrician

Representing State Medical Association

Dr. W. M. Hart, Florence, S. C., Practicing Pediatrician

Representing State Medical Association

Dr. J. M. Albergotti, Orangeburg, S. C., Practicing Pediatrician

Representing State Medical Association

Mr. Roscoe Langdon, Division Manager, McKesson and Robbins, Inc., Columbia, S. C.

Representing wholesale druggists

Mr. John W. Davis, Columbia, S. C.

Representing retail druggists

Mr. J. C. Holler, Director, Division of Instructions, State Department of Education, Columbia, S. C.

Representing Department of Education

Mr. B. B. Leitzey, Florence, S. C., Assistant Superintendent Florence Schools

Representing Parents and Teachers

Dr. G. S. T. Peeples, State Health Officer and Liaison Officer, Columbia, S. C.

Representing Health Agencies

Dr. T. W. Wyatt, Drug Inspector, State Board of Health, Columbia, S. C. and Dr. G. E. McDaniel, Director, Division of Disease Control and Epidemiologist, State Board of Health, Columbia, S. C., consultants to the Committee.

A. 1. Responsibilities of the advisory Committee are to advise and assist the Liaison Officer and the State Board of Health in carrying out the voluntary control program. It will be their responsibility to coordinate the participation of the various professional, educational, voluntary agencies, and lay groups to insure the successful operation of the program.

2. The Committee will determine the percentage distribution of vaccine for purchase with public funds and for commercial sale. This percentage may be changed as availability of public funds and vaccine supply indicate.

3. Information to the public will be made available through all available means of education, such as press, radio, television, etc.

4. The Advisory Committee will review the State Plan from time to time and revise it as it becomes necessary.

5. The program is to begin as soon as poliomyelitis vaccine becomes available for distribution to the State. The N.F.I.P. program was completed in S. C. on July 15 for first and second doses to first and second grade school children and boosters in the field trial area.

An appropriation of $500,000 was passed by the S. C. Senate for the purchase of poliomyelitis vaccine but it did not reach the the House for action.

The S. C. Medical Association at its annual

meeting in May, adopted a resolution unanimously that no child in S. C. would be denied poliomyelitis vaccine because of inability to pay for the medical services for its administration.

U. S. PUBLIC HEALTH SERVICE

A. The State Board of Health will notify the Public Health Service of the percentage allocation of vaccine for purchase from public funds and for commercial sale and provide such other reports as the Public Health Service needs.

The State Board of Health will inform the Public Health Service of any inequities that may be discovered.

MANUFACTURERS

It is understood that manufacturers will send copies of all invoices of poliomyelitis vaccine shipped into S. C. to the State Health Officer and that they will make adjustments in deliveries in accordance with the recommendations of the State Advisory Committee and that they will distribute the vaccine through the normal commercial channels.

July 25, 1955

The South Carolina State Industrial Nurses Association will hold their (second) annual Symposium, September 23-24 at The Clemson House, Clemson, S. C.

The many friends of Dr. A. W. Browning, prominent Elloree physician, are sorry to hear that he is undergoing treatment at the Baptist Hospital in Columbia.

Dr. Frederick E. Nigels announces the opening of his office for the practice of internal medicine at 51-C Montague Street, Charleston.

Dr. Fred M. Patterson of Greensboro, N. C., a veteran of World War I, has been appointed examining physician, chief grade, in the Veterans Administration Regional office in Columbia.

Dr. M. Grayson Evans has opened his office for the general practice of medicine in Aynor. His office is located in the Aynor Health Center Building on Elm Street.

Dr. Evans was born in Andrews. He graduated from the Medical College of South Carolina in June, 1954. His internship was completed at the Methodist Hospital in Gary, Ind.

Dr. William G. McCuen, native of Greenville, will be associated with Dr. Robert W. Merckle, who recently assumed Dr. A. D. Couch's medical practice in Greenville. They are occupying Dr. Couch's former office on Pendleton Street.

Dr. McCuen was educated at Parker High School, Furman University, Bowman Gray School of Medicine at Winston-Salem, N. C. He has just completed his internship at Barnes Hospital, with Washington University, St. Louis, Mo.

He has also served as a member of the house staff of City Memorial Hospital, Winston-Salem, N. C., and at Memorial Hospital, Johnson City, Tenn.

Dr. Robert K. Myers has been appointed physician at the VA Hospital, Columbia, according to D. S. Slade, manager.

Dr. Myers is a native of Indiana and received his M. D. degree from the Indiana University Medical School, Indianapolis.

Dr. Elbert N. Johnson, Jr., a native of North Carolina, opened an office for the practice of internal medicine at 506 W. Palmetto Street, Florence.

Dr. Johnson is married to Dr. Ruth Smith Johnson, who is already engaged in the practice of pediatrics in Florence.

A graduate of Wake Forest College, Dr. Johnson received his medical education there at the Bowman Gray school of medicine. He completed two years of internship at the City of Detroit Receiving Hospital, Detroit, Mich.

Later, he served two years in the Army which included Korean duty with the 5th Regimental Combat Team. After his discharge, Dr. Johnson received two years of residency training in internal medicine at University Hospital, Augusta, Ga., and Roper Hospital, Charleston.

Dr. Gamewell A. Lemmon has opened an office at 132 N. Washington Street, Sumter for practice of general surgery. Dr. Lemmon received his M. D. degree from Jefferson Medical College, Philadelphia, and interned two years at Jefferson Hospital. He was in the Army two years as a medical officer. He was a surgical resident of St. Elizabeth Hospital. Richmond, Va., for a year, and at Philadelphia General Hospital, four years. He is a diplomate of the American Board of Surgery.

Dr. Leon Marder has opened an office for the practice of internal medicine, gastroenterology and hematology in the Professional Building, 103 E. North Street, the Greenville County Medical Society announced yesterday.

Dr. Marder was born in Brooklyn, N. Y., and received his premedical education at Stanford University and his M. D. degree from the University of Oklahoma School of Medicine in 1949. He interned and was a resident in internal medicine at Michael Reese Hospital in Chicago. Following a tour of duty as flight surgeon and base surgeon with the Air Force, he completed his residency training at the University of Louisville Medical School Hospital.

Two more doctors have announced the opening of offices for the practice of medicine, the public relations

committee of the Greenville County Medical Society said.

They are Dr. John C. Muller and Dr. William W. Pryor, with offices at 710-A Pendleton Street for the practice of internal medicine and cardiology.

Eight doctors have now begun new practices in Greenville since July 1.

Dr. Muller is a native of Dillon and received his B.S. degree from The Citadel and his M. D. degree in 1948 from Duke University School of Medicine. He interned at Grady Hospital in Atlanta and then returned to Duke to complete residency training in internal medicine. He was in the Medical Corps in 1951-53 and served 19 months overseas. For two years he has been an associate in the department of cardiology and an instructor in the department of medicine at Duke Hospital.

Dr. Pryor is a native of Oxford, N. C. He attended Wake Forest College and Duke University School of Medicine, where he received his M.D. degree in 1947. After the completion of his residency training at Duke, he spent two years in the Air Force, serving at the Aero-Medical Laboratory at Wright Air Development Center where his work was primarily concerned with research problems related to respiratory physiology and artificial respiration. In 1953, he returned to Duke as an associate in cardiology and an instructor in the department of medicine. He was certified as a specialist by the American Board of Internal Medicine in February.

ANNOUNCEMENTS

TWENTY-FOURTH V. D. POSTGRADUATE COURSE

Chicago, Illinois—September 26 to 30, 1955

MONDAY—September 26—9:00 to 4:00 P. M.

Panel presentation
Early Syphilis—Diagnosis & Management
Arthur Curtis, Sidney Olansky, Louise E. Tavs
Panel Presentation
Epidemiology of Venereal Diseases
Robert Hansen, Johannes Stuart

TUESDAY—September 27—9:00 to 4:00 P. M.

Panel Presentation
Laboratory Aspects of the Diagnosis of Syphilis
Harold J. Magnuson and Ad Harris
Panel Presentation
Diagnosis and Management of Latent Syphilis
Biologic False Positive Reactions, Syphilis in Pregnancy, and Congenital Syphilis
Loren W. Shaffer, Sidney Olansky, Harold J. Magnuson

WEDNESDAY—September 28—9:00 to 4:00 P. M.

Panel Presentation
Community Organization for Selective Mass Surveys
C. S. Buchanan, William Watson, Ad Harris
Late Syphilis—Diagnosis and Management
Evan Thomas

THURSDAY—September 29—9:00 to 4:00 P. M.

Panel Presentation
Role of Official and Non-official Agencies in Venereal Disease Control
C. A. Smith, Norman Rose, T. Lefoy Richman
Panel Presentation
Chancroid, Lymphogranuloma Venereum and Granuloma Inguinale
Henry Packer

FRIDAY—September 30—9:00 to 4:00 P. M.

Panel Presentation
Special Group Considerations in Program Planning
Ingalls H. Simmons, Donald Harting, Lyle Saunders
Panel Presentation
Gonorrhea and Non-specific Urethritis
Warfield Garson, Samuel S. Ambrose

Applications to attend the course should be directed to the Section of Dermatology, Department of Medicine, University of Chicago, Chicago 37, Illinois, and should include the name, medical school attended, year of graduation, and address of applicant.

THE WINSTON-SALEM HEART SYMPOSIUM

Sponsored by the
Heart Association of Winston-Salem and Forsyth County will be held at the Robert E. Lee Hotel, Winston-Salem, N. C.

FRIDAY, SEPTEMBER 30TH—9:00 a.m.—9:00 p.m.

SPEAKERS:

Charles K. Friedberg, M.D., New York, N. Y.
Hugh H. Hussey, M.D., Washington, D. C.
Arthur J. Merrill, M.D., Atlanta, Ga.

The North Carolina Heart Association Annual Meeting will be held in the same hotel beginning September 29th, having concurrent sessions with the Symposium on September 30th.

SOUTHERN MEDICAL ASSOCIATION
HOUSTON, TEXAS
FORTY-NINTH ANNUAL SESSION, NOVEMBER 14-17, 1955

INVITATION TO ATTEND
SEVENTH ANNUAL SCIENTIFIC ASSEMBLY
SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE
COLUMBIA HOTEL, COLUMBIA, S. C.
TUESDAY, SEPTEMBER 27 AND WEDNESDAY, SEPTEMBER 28

DR. WILLIAM A. LANGE, Detroit, Mich.
Wayne University College of Medicine Faculty. Chief Plastic Surgery Service, Grace Hospital, Detroit, Mich.
"Repair of Soft Tissue Fractures".
"The Technique Used In Plastic and Reconstructive Surgery For Some Common Conditions The Doctor In General Practice Should Understand".

DR. JOHN A. PRIOR, Columbus, Ohio
Professor Medicine, Ohio State University College

Of Medicine. Chief of Pulmonary Diseases, University Hospital, Ohio State University.

"Chronic Lung Diseases".

"Lung Disease In Relation To Cardio-Vascular Diseases".

DR. EDGAR BOLING, Atlanta, Ga.

Assistant Clinical Professor, Emory University Medical School. Chief Proctology Service, Grady Memorial Hospital, Atlanta, Ga.

"Hemorrhoids".

"Rectal Polyps And Rectal Cancer".

DR. ROBERT C. MAJOR, Augusta, Ga.

Clinical Professor of Surgery, Medical College of Georgia.

"Indications And Preparation Of The Patient For Pulmonary Surgery".

PANEL DISCUSSION—"THE PREMATURE PROBLEM"

Moderated by Dr. John Cuttino, Dean
Medical College of South Carolina

Participants—

Obstetrician, Dr. L. L. Hester, Jr.
Associate Professor of Obstetrics and Gynecology
Medical College of South Carolina

Pediatrician, Dr. M. W. Beach
Professor of Pediatrics Medical College of South Carolina

Anesthesiologist, Dr. John M. Brown
Associate Professor of Surgery, Medical College of South Carolina

Nurse, Miss Mary Jo Brown
Clinical Instructor Nursing, Medical College of S. C.

Hospital Administrator (To be announced)

QUESTION AND ANSWER PERIOD ON CHRONIC LUNG DISEASES
DOCTORS PRIOR AND MAJOR

Luncheon Speakers

Dr. O. B. Mayer, President S. C. Medical Association

Dr. Donald Russell, President University of S. C.

Banquet Speaker

Dr. John R. Fowler, Barre, Mass., President of American Academy of General Practice.

PROGRAM AND ENTERTAINMENT FOR THE LADIES

Eleven Hours "Formal" Credit For Full Attendance.

"Greenville Medical Day" will be given on Tuesday, October 4th, 1955 at the Greenville General Hospital, Greenville.

9:30 A. M.—"Recent Advances in Pediatrics" by J. Earle Furman, M. D. Pediatrician of Greenville.

10:00 A. M.—"Recent Advances in Medicine" by Hugh Smith, Sr. Internist of Greenville.

10:30 A. M.—"Radio-isotopes" by Robert Robbins, M. D. Professor of Radio-therapy, Temple Univsity, Philadelphia.

11:00 A. M.—Intermission.

11:15 A. M.—"Recent Advances in Obstetrics" by Robert A. Ross, M. D., Professor of Obstetrics and Gynecology, University Hospital of North Carolina School of Medicine.

11:45 A. M.—"Recent Advances in Surgery" by W. E. Burnett, M. D., Professor of Surgery, Temple University School Of Medicine.

12:30 A. M.—Luncheon—Dining Room, Greenville General Hospital, General Luncheon and Alumni Luncheon.

2:00 P. M.—"Chemo-therapy and Radio-therapy of Cancer" by Robert Robbins, M. D.

3:00 P. M.—"Surgical Treatment of Bowel Cancer" by W. E. Burnett, M. D.

4:00 P. M.—"Surgical Treatment of Gynecologic Cancer" by Robert A. Ross, M. D.

6:00 P. M.—Social Hour — Lobby.

7:00 P. M.—Dinner — Dining Room, Greenville General Hospital.

8:00 P. M.—"Cancer of the Breast" by Dr. J. Elliott Scarborough, Jr. Director of the Winship Clinic, Emory University, Director of the Steiner Clinic, Grady Hospital.

The Greenville County Medical Society Auxiliary invites visiting wives to a Luncheon at the Greenville Country Club and to a Fashion Show and Tea in the afternoon.

The National Alumni Group of the Medical College of South Carolina will have cocktails and dinner Tuesday evening, November 15, at the meeting of the Southern Medical Association. Please make inquiry and get tickets at registration booth on arrival.

Jack C. Norris, M. D., Secty.

MEDICLINICS of MINNESOTA, organized to provide practical medical education for practicing physicians, announces its first course. This program will consist of thirty-two hours of instruction, four hours each day, covering a period of eight days. The course will be made up of lectures and panel discussions on subjects having an everyday application in the general practice of medicine and presented by members of a medical faculty well qualified to assume teaching roles.

This course will be given in Fort Lauderdale, Florida from March 5 - 14, 1956. The program is under the local sponsorship of the members of the Academy of General Practice of Broward County. The American Academy of General Practice is authorizing thirty-two hours of credit for postgraduate study for those of its members enrolled in this class.

Make your reservation early and confirm it by sending your check, payable to MEDICLINICS of MINNESOTA in the amount of $50.00 to MEDICLINICS of Minnesota, 516 Medical Arts Bldg., Minneapolis 2, Minn.

METAMUCIL® IN BOWEL MANAGEMENT

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The gentle distention of the bowel wall provided by Metamucil® is physiologically corrective in constipation management.

Normal peristaltic movements of the bowel depend on the consistency and quantity of the material within the lumen. In constipation, hypohydration accounts for the hard consistency and inadequate quantity of the fecal mass. With Metamucil, stool quality becomes soft and plastic, while stool quantity is increased to produce gentle distention, the natural stimulus to peristalsis.

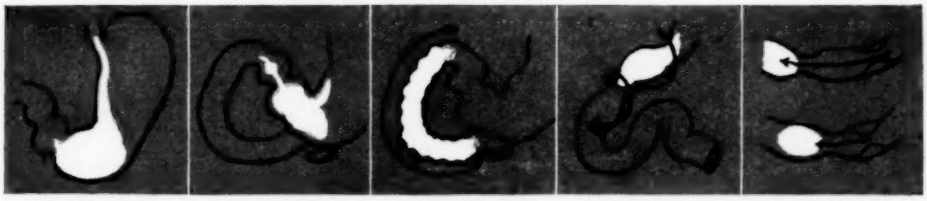
Metamucil is the highly refined mucilloid of the Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The usual adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice one to three times daily. An additional glass of liquid may be taken if indicated.

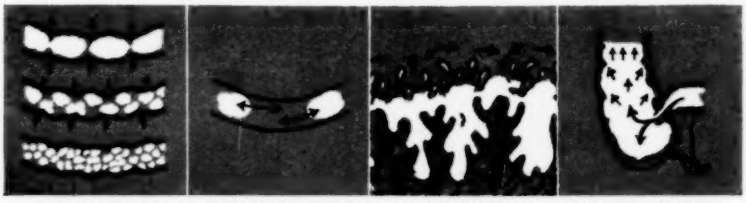
Metamucil is supplied in containers of 1, ½ and ¼ pound.

G. D. Searle & Co., Research in the Service of Medicine.

TYPES OF MOVEMENT WITHIN THE BOWEL



Food Breakdown | Pyloric Dilation | Duodenal Churning | Spiral Propulsion | Rapid: Slow Peristalsis



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SEARLE

ANNOUNCEMENT OF REGULAR CORPS EXAMINATIONS FOR MEDICAL OFFICERS UNITED STATES PUBLIC HEALTH SERVICE

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held in various places throughout the country on *November 15, 16, and 17, 1955.*

Appointments provide opportunities for career service in clinical medicine, research, and public health. They will be made in the ranks of Assistant and Senior Assistant, equivalent to Navy ranks of Lieutenant (j.g.) and Lieutenant, respectively.

Entrance pay for an Assistant Surgeon with dependents is $6,017 per annum; for Senior Assistant Surgeon with dependents, $6,918. Provisions are made for promotions at regular intervals.

Benefits include periodic pay increases, 30 days annual leave, sick leave, medical care, disability retirement pay, retirement pay which is three-fourths of annual basic pay at time of retirement, and other privileges.

Active duty as a Public Health Service officer fulfills the obligation of Selective Service.

Requirements for both ranks are U. S. citizenship, age of at least 21 years, and graduation from a recognized school of medicine. For the rank of Assistant Surgeon, at least 7 years of collegiate and professional training and appropriate experience are needed, and, for Senior Assistant Surgeon, at least 10 years of collegiate and professional training and appropriate experience are needed.

Entrance examinations will include an oral interview, physical examination, and comprehensive objective examinations in the professional field.

Application forms may be obtained by writing to the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C. Completed application forms must be received in the Division of Personnel *no later than October 15, 1955.*

BOOK REVIEWS

MASTER SURGEON by Ferdinand Sauerbruch (An autobiography with English translation) by G. Renier and Anne Cliff, Thomas Y. Crowell Company, New York, 1954.

The late Dr. Sauerbruch, one of the most noted German surgeons in recent times, tells the story of his life in a quite interesting fashion. The language is pitched for the comprehension of the general public as well as the medical profession.

Dr. Sauerbruch describes in some detail his pioneer work in the development of thoracic surgery. His early discouragements and later rapid rise to success and fame are depicted without any pretense at undue modesty. Those not already familiar with it will be illuminated by the mechanics of promotion to professorships in the German universities. His personal relations with Hindenburg and Ludendorff are described. He rather disclaims any enthusiasm for the movement of the Nazi party. Unfortunately, he does not describe in any detail his activities as Surgeon General during World War II. This is a true success story of a poor boy who rose to the highest position in German Surgery as Head of the Department at the University of Berlin. It makes interesting reading throughout.

F. E. Kredel, M. D.

AN OUTLINE OF THE TREATMENT OF FRACTURES 5TH EDITION, 1954. By the Committee on Trauma of the American College of Surgeons.

This small book is exactly what the title implies. It makes no pretense of covering the whole field of orthopaedics. It is a guide for students and for the physician who treats an occasional fracture. The text is concise and easily understood. The illustrations though simple line drawings are quite good The section on radiography is particularly good, especially for the practicing physician who has his own x-ray machine or the clinic or small hospital with x-ray equipment but without a radiologist. The fracture aphorisms are valuable rules of thumb for the student and are easily remembered. The portion on first aid is valuable to internes, students, and nurses who are working in the emergency room. All in all, this is a valuable book and I hope in future editions, the committee will continue to keep it concise and small enough to fit the pocket of an internes jacket.

R. M. Paulling, M. D.

THESE ARE YOUR CHILDREN. Expanded Edition by Gladys Gardner Jenkins, Staff Lecturer. Helen Schacter, Ph.D., Consulting Psychologist and Lecturer, and William W. Bauer, M. D., Director, Bureau of Health Education of American Medical Association. Scott Foresman and Company. Chicago. Atlanta, Dallas, New York, 1953. 320 pages, with numerous illustrations, index and bibliography, $4.75.

One hears frequently that "there is nothing new under the sun." This statement can easily be disproved. This book which looks and is entirely different from many others is a case in point. It is only recently that it has been on the market. A hasty going over will show how far it has departed from nearly all of its predecessors.

The volume has 14 chapters, arranged chiefly for different ages, although there are certain general topics that apply to all. The chief theme of this work is that physical health while essential is not sufficient. Satisfactory mental and psychological normality is required for one to live in this world with others and to have social and emotional integration.

The authors stress the point that while all children are basically alike, there are certain differences of great importance. Heredity of which we still know

very little is a factor that so far we can not and dare not try to control. But environment and upbringing at home and at school are of tremendous importance, and these are the matters that should be the concern of all of us.

In this text it is emphasized that growth is a continuous process, and one need not be surprised at times by a slow change, and at others by a surprising change. Really the mental and physical progress in the average child is amazing. However some parents and a few teachers expect too much, and are impatient.

As one reads he sees that the characteristics at different ages are brought out in a clear and interesting way.

The photographs which are very fine and life-like are in themselves worth looking at, and impress the text forcibly.

One chapter is entitled, The Very Beginning, another, Part Baby, Part Child. Then there are others, such as, A Good Day in Kindergarten, Jimmy is Six, Nine, Has Many Adjustments, and Not Quite Grown Up.

While this contribution can be used by all who deal with infants and children, especially social-workers, doctors, psychologists, college students and many others, it should be of great value to the intelligent parent who wishes to adequately rear the child, for it covers the physical, mental, social and emotional growth.

One can say unhesitatingly that THESE ARE YOUR CHILDREN is not only well arranged, but attractive, very interesting, and most informative.

R. M. Pollitzer, M. D.

PERINATAL MORTALITY IN NEW YORK CITY—(A Study analyzed and reported by Schuyler G. Kohn, M.S., M.D., Dr. P. H.—Harvard Univ. Press, Cambridge, Mass. 1955. Price $2.50)

A careful study of 955 perinatal deaths by a committee of experts reaches the conclusion that 35% of the deaths were preventable, and that in all the deaths "unavoidable disaster" played a part in only 55%. Errors in medical technique and judgment, faulty prenatal and pediatric care are cited with disturbing frequency.

This is a valuable contribution to a subject of active current interest. Our South Carolina problem of deficiency of rural medical care and frequency of midwife care (21 percent of all our births) does not play a big part in New York. Being nonsegregated, this report does not offer full correlation with our situation in which Negro perinatal mortality is so much higher than that of the white race, and depends on somewhat different factors.

J. I. W.

SCISSORISMS

Dear Cousin, much I wish for your advice
Tis on a point extremely nice
'Bout which my mind is in an odd quandry
By your opinion I would fain abide
Bewixt two personages to decide
My Dog and my Apothecary

To state the case—Monsieur L'Apothecaire
Thinks proper to declare
That I must drink a pint of bark* a day;
Because, he says, twill be the way
To strengthen and recruit me now I'm wasted
That may be true; yet still I'm loth to drink
Simply because I think
It is the damnedest stuff I ever tasted.

But that's not all; for you must know
A noisy House Dog that I keep
Doth every night contrive it so
That I can get no sleep;—
And am not I in piteous plight
With bark all day and bark all night?

Now, prithee, cousin, tell me what to do
Betwixt the two
"Why, hang the dog"—I think I hear thee say.
Alas, poor Tray!
Would that be treating thee quite fair?
If either must be hang'd, I own
I'd rather leave the dog alone
And hang the other spark who deals in bark—Monsieur L'Apothecaire.

CITY GAZETTE, (Charleston)—Aug. 4, 1804

*For the unread—bark means cinchona.

The very finest work in scientific medicine is more readily misinterpreted in terms of financial gain and claims of quick cures of undiagnosed cases, rather than advanced by authoritative explanation of principles and vital processes, as our over-filled waste-paper baskets testify every day. It is depreciatory that these elaborate advertisements are often accepted as a source of information by practitioners (with added expense to the patient who ultimately pays for them) and indicates a glaring defect in policy of medical journals. Nearly as pernicious is the unbalanced reporting of "medical news" in the daily press, in which inaccuracies develop a compound distortion by papers copying one from another.

E. G. D. Murray,—A Plea for Constructive Speculation. Bull. Hist. Med. 29: 71.

SOUTH CAROLINIANA

The Causes of Death Following Esophageal Resection for Carcinoma. By Edward F. Parker, M. D., and Louie B. Jenkins, M. D. J. Thoracic Surg. 29:373-380, Apr. 1955.

The surgical treatment of primary epidermoid carcinoma of the esophagus, as distinguished from primary adenocarcinoma of the cardia of the stomach invading the lower end of the esophagus, has been extremely difficult. With few exceptions, patients with carcinoma of the esophagus present themselves in a moderately severe to severe state of dehydration and malnutrition. Further, a high proportion of tumors are situated in the region of the aortic arch and the bifurcation of the trachea, so that the technicalities involved in the extirpation of tumors in this region when combined with restoration of the alimentary tract in a single stage operation have become very complex.

In an attempt to find some reason or reasons for the poor results of the surgical treatment of epidermoid carcinoma of the esophagus, an analysis of 210 patients was made with particular regard to a critical review of causes of death in the patients treated by resection. The mortality rates for resections of the thoracic esophagus with and without restoration of continuity of the alimentary canal were presented. The causes of death were enumerated, the most frequent being failure of healing of the anastomosis with esophagopleural fistula and empyema. The causes of death were analyzed from the standpoint of the status of patients on admission, the preoperative therapy and its duration, the operative technique and the postoperative therapy. The operative mortality must be reduced in order to justify continued use of resection. in the treatment of lesions in the region of the aortic arch, and consideration on the needs for the reduction in operative mortality were presented.

Pulmonary Hemorrhage. E. F. Parker, M. D., Charleston. Am. J. Surg. 89:316-318. Feb. 1955. 318, Feb. 1955.

Pulmonary hemorrhage in the sense in which it is used in the discussion may be defined as hemoptysis originating in the lower respiratory tract, consisting of the pulmonary parenchyma, the bronchi and trachea. Hemoptysis is defined as the expectoration of blood, regardless of its source. Since a patient presenting the complaint of expectoration of blood is usually ignorant of the source of the blood, all possible causes of hemoptysis have to be considered in a discussion of pulmonary hemorrhage.

Injury or disease of any structure communicating with the naso-oropharynx and the tracheo-bronchial tree must be considered in the differential diagnosis of hemoptysis. Even the possibility of hematemesis must be remembered. The patient may be unable to state whether the blood appeared following a cough, vomiting or a clearing of the nose to aspirate any discharge from the naso-pharynx. Sometimes there is no act such as coughing associated with the appearance of the blood. The patient may state that there is merely a sensation of something in the throat and a simple clearing of it produces the blood.

A partial list of the causes of hemoptysis is presented, after which the diagnostic procedures available at the present time for the study of patients with hemoptysis are presented. The importance of each and the indications for each are discussed briefly.

Dramatic Response to Cortisone Therapy in a Case of Serum Neuritis. Hugh Smith, M. D. and Hugh Smith, Jr., M. D., Greenville. J.A.M.A.: 157:906-907, March 12, 1955.

One of the unhappy complications of administration of blood serum for any purpose is neuritis, which is often excruciatingly painful and frequently leads to permanent damage. Heretofore, therapy has not been particularly successful. Since the serum neuritis is thought to be due to an allergic response with edema and ischemia of nerves, it was felt that Cortisone with its anti-inflammatory action should be helpful and a case is reported in which the response was dramatic with considerable and very rapid improvement.

Topical Anesthetics for the Eye: A Comparative Study. J. W. Jervey, M. D., Greenville. South. Med. J. 48:770, July 1955.

In this study an attempt has been made to determine the comparative value of several local anesthetics commonly used in office practice.

Observations were made and recorded in more than 1,000 cases using 10 anesthetic preparations. Some 20 instillations were made in my own eyes. Approximately 50 eyes were used for each anesthetic.

Ophthaine had the shortest onset time and the longest duration. It also seemed to produce less discomfort.

Incorporation of Pontocaine with methyl cellulose appeared to retard the action of the anesthetic, an observation made by Swan. I have observed that the mixture increases the toxicity. This is seen in the very definite increase in staining of the cornea after tonometry when Pontocaine is used in solution in methyl cellulose. It is well known that methyl cellulose will protect the cornea from the tonometer, but it should be instilled after the eye has been anesthetized and the tears have removed all excess of the anesthetic.

All local anesthetics have a deleterious effect upon the cornea. They all increase the drying effect of air on the precorneal film, and all at times cause a stippling resembling that seen in kerato-conjunctivitis sicca.

Antibiotics in Anorectal Lesions. Leon Banov, Jr., M. D. Antibiotics Annual 1954-55, p. 263-268.

This paper, presented at the 1954 Antibiotics Symposium, sponsored by the U. S. Department of Health, Education, and Welfare, in Washington, D. C., was a preliminary report on clinical experiences with erythromycin and tetracycline in the management of the common nonspecific inflammatory lesions of the anorectum.

Because infection appeared to be a causative factor in the development of hemorrhoidal disease, enlarged anal papilla, anal fissure, perirectal abscess, fistula in ano, and other anorectal inflammatory lesions, the use of antibiotics has a sound and logical basis. Although the use of the antibiotics is palliative, nevertheless palliation is often necessary in the management of anorectal lesions. The antibiotics are a useful adjunct in the management of proctologic lesions because they combat the infection, relieve the pain of inflammatory edema, and reduce morbidity.

The broad-spectrum antibiotics have a definite place in the management of the common anorectal lesions.

WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C. **Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.**

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Dr. Walter Mead, Florence, Chairman; Dr. Wm. Prioleau, Charleston; Dr. David A. Wilson, Greenville; Dr. Austin T. Moore, Columbia; Dr. Thomas R. Gaines, Anderson; Mr. M. L. Meadors, Florence, Ex-Officio.

NEWS NOTE

Mrs. Alfred Burnside has been appointed by the National President to serve on the Central Office Committee for a term of one year. That committee has charge of the National Auxiliary Office in respect to maintenance and clientele.

MRS. MAY ANNOUNCES FALL BOARD MEETING

The fall meeting of the executive board of the Auxiliary to the South Carolina Medical Association will be held in Florence, S. C. at the Country Club on Thursday, October 6. Further announcements as to time and reservations will be forthcoming. Presidents-elect are reminded that they are invited to attend this meeting.

OFFICERS AND CHAIRMEN, 1955-56, WOMAN'S AUXILIARY

President, Mrs. Charles R. May, Jr., 200 Tyson Ave., Bennettsville; Pres.-Elect, Mrs. Gordon Able, McCaughrin Ave., Newberry; First Vice-Pres., Mrs. Frank Warder, Anderson; Second Vice-Pres., Mrs. J. O. Fuelenwider, Pageland; Third Vice-Pres., Mrs. Rufus Bratton, 328 Oak Drive, Rock Hill; Fourth Vice-Pres., Mrs. Wayne Reeser, 804 Burroughs Ave., Conway; Recording Secretary, Mrs. M. J. Boggs, Abbeville; Historian, Mrs. S. Edward Ezard, 44 King St., Charleston; Treasurer, Mrs. George Orvin, 106 Murray Blvd., Charleston; Corresponding Secretary, Mrs. Douglas Jennings, Jr., East Main St., Bennettsville; Parliamentarian, Mrs. Alfred Burnside, Pine Acres, Arcadia, Columbia.

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National Bulletin—Mrs. Frank Davenport, Timmonsville.

Editor, State Bulletin—Mrs. N. D. Ellis, Jr., 628 Fairway Drive, Florence.

Today's Health—Mrs. C. F. Higgins, Box 549, Easley.

Printing—Mrs. A. T. Moore, 303 Saluda Ave., Columbia.

Convention—Mrs. J. K. Owens, Jr., 300 Tyson Ave., Bennettsville.

Finance—Mrs. George Dawson, 617 Greenway Drive, Florence.

Jane Todd Crawford Mem. Fund and Nurse Recruitment—Mrs. Bryan Michaux, Dillon.

Legislation—Mrs. K. M. Lippert, 13-A Veteran's Hospital, Columbia.

Revisions—Mrs. W. H. Folk, 721 East Main St., Spartanburg.

Public Relations—Mrs. J. K. Webb, 140 W. Mountain View Road, Greenville.

Doctor's Day—Mrs. Ripon LaRoach, Camden.

Membership—Mrs. R. E. Livingston, 2230 Main St., Newberry.

Research & Romance of Medicine—Mrs. George Smith, Florence.

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Heart Education—Mrs. Charles H. White, 14 Crowson Drive, Sumter.

Mental Health

Handbook—Mrs. David A. Wilson, Lake Circle Drive, Greenville.

Rally Day, Nurse Recruitment—Mrs. W. H. Williams, Jr., 616 Meadowbrook Lane, Rock Hill.

Civil Defense—Mrs. H. B. Morgan, Greenville Highway, Ware Shoals.

Rural Health—Mrs. John Brewer, Kershaw.

Safety—Mrs. K. G. Lawrence, Timrod Park Drive, Florence.

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President—Mrs. John T. Cuttino, Route 1, Box 291, Charleston; Pres.-Elect—Mrs. Vince Moseley, 51 East Battery, Charleston.

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President—Mrs. Samuel B. Mogle, Walhalla; Pres-Elect—Mrs. Harry B. Mays, Fair Play.

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President—Mrs. Fritz Johnson, Mullins; Pres. Elect—Mrs. Earle Hodge, Cheraw.

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President—Mrs. C. F. Higgins, Box 549, Easley. Pres.-Elect—Mrs. J. A. White, Easley.

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York

President—Mrs. Alton G. Brown, 904 Myrtle Dr., Rock Hill; Pres.-Elect—Mrs. Thomas Murrah, Meadowbrook Lane, Rock Hill.

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